Report of the Manitoba Regional Health Authority External Review Committee

FEBRUARY 2008

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Executive Summary

The overall assessment of the External Review Committee is that the establishment of Regional Health Authorities (RHAs) in 1997 has been positive, providing Manitobans with benefits that probably would not otherwise have materialized. The system has a number of strengths and many "best practices" have been implemented in the regions. There are also areas in which the regional system could be improved and these are presented in this report.

The Review Committee was mandated to make recommendations to the Ministers of Health and Healthy Living on how to further enhance the province's Regional Health Authorities system into the future.

The Committee's consultation strategy consisted of the following major components:

1) An initial consultation meeting with all of the board chairs and chief executive officers (CEOs) of the regions.

2) Questionnaires sent to the RHA board chairs and CEOs, chairs of District/ Community Health Advisory Councils, chairs of non-devolved facilities and First Nation and Metis groups.

3) Survey questionnaires sent to RHA managers and facility managers, RHA Board members and members of Community/District Health Advisory Councils.

4) Requests for input sent to senior managers with Manitoba Health and Healthy Living. Discussions were also held with individual senior managers from Manitoba Health and Healthy Living.

5) Requests for input from specific external stakeholder groups.

6) Meetings with stakeholder groups representing municipalities, regions, and First Nation and Metis people.

7) Ongoing meetings with the Advisory Committee to the External Review Committee. The list of Advisory Committee members and its terms of reference are in Appendix 13.

8) Requests for public input through media announcements.

9) Follow-up consultation meetings with the board chair and CEO of each of the RHAs.

External consulting organizations were used to assist in the design and administration of the online surveys and assist in the selection, examination and interpretation of pre-existing performance measures.

The Review Committee has reached a number of conclusions regarding regionalization and is making 35 recommendations on how regionalization can be improved. The list of recommendations is contained in Section 16. The Review Committee was also mandated to identify the "best practices" in the regions that might be shared with other regions. Some of the "best practices" are described in the text of the report, and the Committee has prepared a separate report that documents all of the best practices submitted.

The major conclusions of this review are:

- Comparisons of regionalization in Manitoba with regionalization in other provinces are difficult because of a lack of reliable comparative data, the different dates of implementation and the different regionalization models used. Nevertheless, the Committee's research indicates that the regionalization issues faced in other provinces are similar to the issues faced in Manitoba.

- Regionalization was implemented to achieve specific objectives and benefits as discussed in this report. The information gathered by the Committee indicates that to varying degrees, the benefits have been achieved. Further improvements will require fundamental changes to systems and structures as detailed in the recommendations.

- Performance indicators presented in this report provide a reasonably balanced perspective of health system performance in Manitoba and context for recommendations related to some of the goals of regionalization. These goals include linking prevention, population health and treatment into a seamless

continuum of care, physician recruitment and efficient and effective service delivery. Although Manitoba spends more than the Canadian average per capita on health care, Manitoba's health system performance, related to the measures the Review Committee has selected, may not reflect a comparative benefit from this additional spending. This could mean that money is not being allocated appropriately to maximize performance, that the structures and processes being used in Manitoba are not as effective as they could be, that demographic and socio-economic factors of the Manitoba population affect the health outcomes or a combination of all of the above.

- There are numerous examples of improvements in health care for Manitobans that are directly related to the implementation of regionalization.

- Regionalization in Manitoba could be more effective if Manitoba Health and Healthy Living delegated more authority and accountability for health outcomes to the RHAs and set targets for specific RHA outcomes.

- Governance of the RHAs could be more effective with improved methods of appointing board members, clarification of the role of the board, implementation of an equitable compensation level and enhanced accountability processes. For example, the requirement for Government approval of RHA decisions related to changes in patient-care services diminishes the accountability of boards and CEOs.

- A chronic shortage of qualified staff is a major barrier to effectiveness in all regions. The Physician Resource Coordinating Office of Manitoba Health and Healthy Living is an example of how centralization of the initial recruitment processes benefits all the RHAs. A more centralized approach to human resources planning for all health-care disciplines is recommended.

- The reduction in the number of front-line management positions (i.e. supervisors, unit or team managers) and senior management positions within the RHAs has created gaps in leadership and in many instances has increased the span of control of many managers beyond a reasonable level. Critical human resource development functions are not being performed because of lack of time.

- Although the comparability of data on administrative costs between regions in Manitoba and those in other provinces is problematic, these costs within the RHAs in Manitoba appear to be, on balance, at an expected level in comparison to RHAs in other provinces.

- Many regions are not utilizing generally accepted quality and efficiency improvement strategies such as Six Sigma, lean principles or other proven process re-engineering programs that could lead to better resource utilization.

- The effectiveness of the Community or District Health Advisory Councils for obtaining input varies throughout the regions. Regions are not held accountable for how well they obtain community input on an ongoing basis. For regionalization to reach its full potential, communities must take ownership of their region's health issues. In addition, RHAs should develop and publish regional service plans that describe the mix of services and service volumes that will be offered in each community.

- The accountability relationship between Manitoba Health and Healthy Living and the RHAs does not include quantifiable performance targets (with the exception of components of the provincial wait-time strategy). Greater use of performance targets by Manitoba Health and Healthy Living and the RHAs would improve accountability for results and ensure that the RHAs are able to pursue provincial priorities as well as local priorities.

- In the area of provincial funding, important work is being done to develop a much needed transparent model for allocating funds to RHAs. Improvements are required in areas such as having the provincial government notify RHAs of their annual funding level well in advance of the fiscal year, the benchmarking of RHA efficiencies for budget development, and the use of alternative financing options to enable the greater use of capital by the RHAs for safe, efficient and effective care. Manitoba Health and Healthy Living and the RHAs also need to develop funding methodologies for hospitals and personal care homes that are based on patient and resident level-of-care requirements.

- Manitoba has consistently spent less on information and communication technologies (ICT) in health care than most other provinces. Manitoba RHAs, overall, have very limited computerization and a very large backlog of needs for investment in ICT. To improve the effectiveness of regionalization, the Government of Manitoba needs to make ICT a much greater priority and fund it accordingly.

- The fact that the Aboriginal population in Manitoba continues to have a much poorer health status than that of the non-Aboriginal population underscores the need for provincial, federal, RHA, and First Nations officials to resolve jurisdictional issues that stand in the way of the provision of health services.

- While regionalization has led to a general improvement in the access to and coordination of health services in the province, the Review Committee provides recommendations to make improvements to the delivery of chronic-disease management, addictions treatment, patient safety and Emergency Medical Services.
- There is a need for more formal mechanisms for inventorying, validating and sharing Manitoba best practices and the best practices from other provinces among all of the Manitoba RHAs.

1. Introduction

Background and context of the external review

The Regional Health Authorities Act came into force on April 1, 1997, creating regional health administrative structures with responsibility for delivering and administering health services in specific geographic areas. The *Act* specified the governance and administrative structures for the regions, as well as the process for obtaining community input into each region's health plan. There are eleven Regional Health Authorities operating under the requirements of the *Act*. The Regional Health Authorities took responsibility for both institutional and community-based health services in their regions. This included not only hospitals and personal care homes, but home-care services, mental-health services, and public-health services.

At the time of regionalization, some hospital and personal care home (PCHs) boards of directors chose not to dissolve themselves and therefore maintained responsibility for the administration of their facilities. These facilities were deemed to be "non-devolved," since they had not devolved their administrative responsibility to the RHA. Those facilities that became administratively part of the RHA when their boards of directors were dissolved were deemed to have "devolved." In rural Manitoba, the majority of facilities devolved, while the majority of facilities in the Winnipeg Regional Health Authority (WRHA) were non-devolved. In both situations, funds are directed through the RHA to all facilities within each region.

One of the benefits of regionalization has been improved communication and coordination of the health care delivery system processes between Manitoba Health and Healthy Living and health services provider organizations. Prior to

regionalization, the Department communicated with 119 individual entities as compared to 11 entities that currently exist post-regionalization.

Map 1.1 shows the RHAs and their boundaries. Table 1.1 gives the population figures for each RHA. The data in Table 1.1 indicate the wide range in the population base of the RHAs. These differences, coupled with the large geographic area covered by many of the RHAs, create a unique set of challenges for regionalization in Manitoba. With 56% of the province's population and 47% of the Manitoba Health and Healthy Living budget, the Winnipeg Regional Health Authority (WRHA) dominates the system in terms of the number of people served and the size of its budget. Furthermore, significant proportions of the population of some RHAs receive their health services outside of their home region. For example, the Winnipeg Regional Health Authority is the only RHA that provides a number of highly specialized services. In some instances these services involve very sophisticated/specialized equipment, and access to specialists and other services that patients require which may not be available or feasible in their region. During the course of this review, the RHAs identified a close and direct working relationship with the WRHA. Similarly, the Brandon Regional Health Centre has the largest variety of specialty programs and diagnostic services outside of Winnipeg and functions as a referral centre for surrounding RHAs. There is little, if any, evidence or research to indicate the optimum size of health regions in the Canadian context.

Table 1.1: Population figures for Manitoba RHAs, March 2007

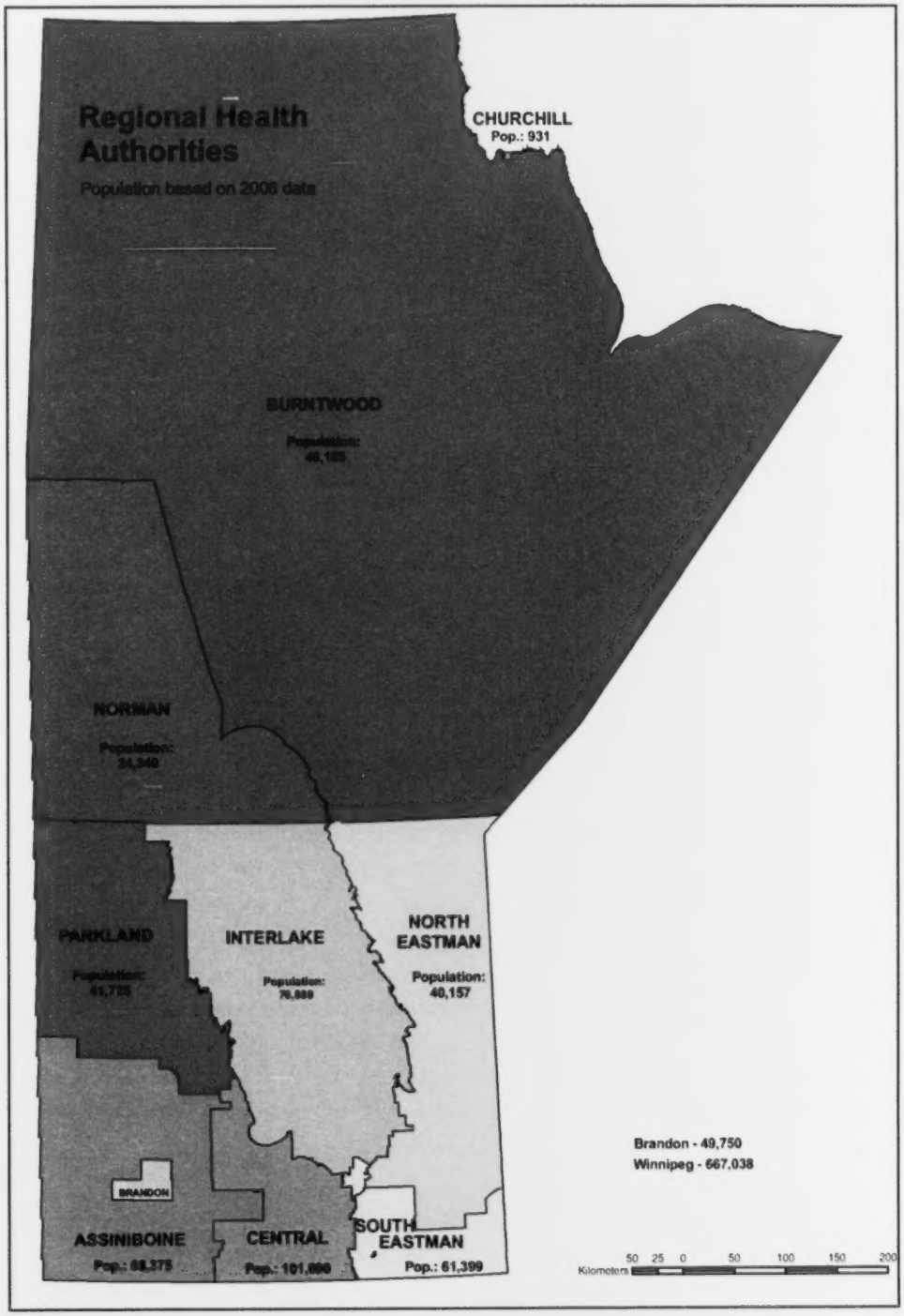
Regional Health Authority	Population
Assiniboine Regional Health Authority	68,375
Brandon Regional Health Authority	49,750
Central Regional Health Authority	101,690
Parkland Regional Health Authority	41, 725
Interlake Regional Health Authority	76,889
Norman Regional Health Authority	24,340
Burntwood Regional Health Authority	46,163
Churchill Regional Health Authority	931
North Eastman Regional Health Authority	40,157
South Eastman Regional Health Authority	61,399
Winnipeg Regional Health Authority	667,038

The transition to a regional model was not instantaneous. Several years were required for the initial implementation; and since then change has been continuous, the most significant being the combining of some of the original RHAs.[1] This ongoing change is an important factor for this review, as the Committee was made aware of the changing nature of regionalization on many occasions.

In conducting this review, the Committee was clear that its mandate was not to evaluate the effectiveness of the individual RHAs. Although much of the data

1 In 1999, the Winnipeg Hospital Authority and the Winnipeg Community and Long Term Care Authority were combined to form the WRHA. In 2002 the Marquette RHA and the South Westman RHA were combined to form the Assiniboine RHA.

Map 1.1: Manitoba Regional Health Authorities boundaries.



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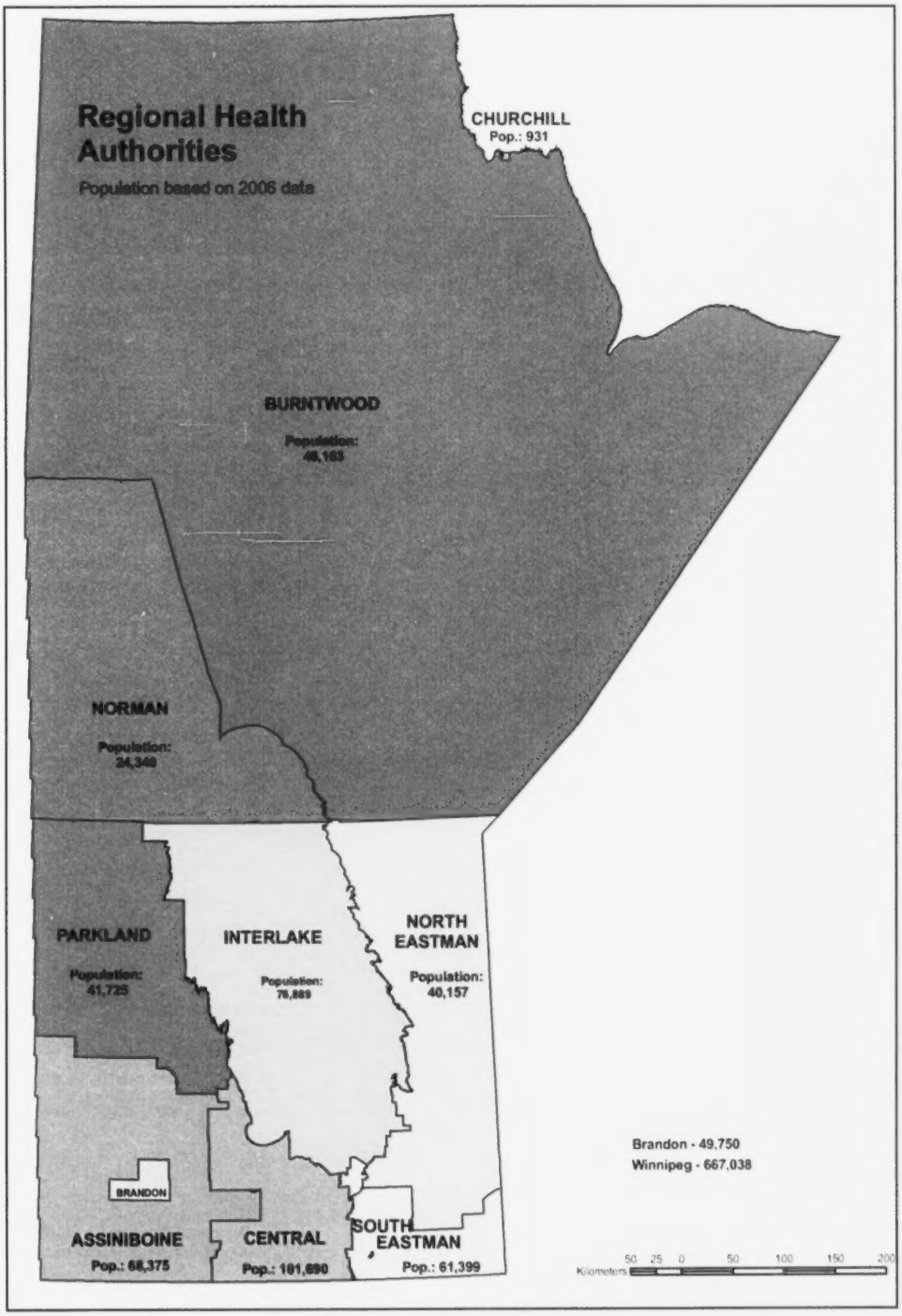

and information that the Committee assessed came from individual RHAs, the Committee abstracted from the regional data and formed overall judgments regarding the issues contained in the Terms of Reference.

The Regional Health Authority External Review

In April 2007, the government appointed the Regional Health Authority External Review Committee to make recommendations to the Ministers of Health and Healthy Living on how to further enhance the province's system of regionalization. The review was to be conducted by a three-person committee consisting of Dr. Jerry Gray (chair), Tom Closson and Shirley Delaquis. Biographies of the committee members can be found in Appendix 1.

The Review Committee's terms of reference were as follows:

RHA Review Terms of Reference

1) Mandate & Process

The mandate of the external review is to make recommendations to the Ministers of Health and Healthy Living on how to further enhance the province's Regional Health Authorities into the future. Manitobans will have the opportunity to submit their views by mail, email or through the website. Specifics of the process will be determined by the external reviewers in consultation with the Ministers of Health and Healthy Living and the RHAs.

2) Deliverables

1. Develop and submit a final report to the Ministers of Health and Healthy Living by December 2007.
2. Examine and recommend strategies for improvement in the following areas:
   a. **Sharing Models of Success:** examining the experience with regionalization in other provinces and comparing the performance of similar regions throughout Canada to help in the identification of best practices in Manitoba and to identify best practices elsewhere that can be implemented here. As well, identifying areas where particular Manitoba RHAs have shown leadership and innovation in improving patient care. The review will examine effectiveness and outcomes; clinical and operational efficiency; the match between service capacity and patient needs, and the integration of care across the continuum and make recommendations on how best practices can be extended to all RHAs.
   b. **Administration:** reviewing administrative structures and costs in terms of appropriateness, transparency, value-for-money and comparability with similar jurisdictions. In addition the review will examine how provincial

programs or province-wide costs can influence the administrative costs of single regions.

c. **Accountability:** reviewing the financial and managerial accountability tools that RHAs have put in place and examining how RHAs can further increase accountability to patients and taxpayers. Reviewing the governance practices and structures of each of the Regional Health Authority's Board of Directors to recommend improvements to governance models and increased accountability.

d. **Further Enhancing Patient Care**: examining how Manitoba Health and Healthy Living and RHAs can best attain common goals and provincially established priorities, such as wait time reduction and prevention and health promotion, in a regional system.

e. **Community Participation and Responding to Local Needs:** identifying methods of increasing community participation in regional decision making about how to best address the unique health issues of each region and examining the balance of the size, scale and responsibilities of regions in meeting the mandate of improving patient care.

The Review Committee's work plan

The Review Committee's consultation strategy provided the opportunity for input from all stakeholders. The consultation strategy consisted of the following major components:

1) An initial consultation meeting with all of the board chairs and chief executive officers (CEOs) of the regions.

2) Questionnaires sent to the RHA board chairs and CEOs (Appendix 3), chairs of non-devolved facilities (Appendix 4), First Nation and Metis groups (Appendices 6 and 7) and chairs of District/Community Health Advisory Councils (Appendix 8).

3) Survey questionnaires sent to RHA managers and facility managers (Appendix 9), RHA Board members (Appendix 10), and members of Community/District Health Advisory Councils (Appendix 11).

4) Requests for input sent to senior managers with Manitoba Health and Healthy Living. Discussions were also held with senior managers from Manitoba Health and Healthy Living.

5) Requests for input from specific external stakeholder groups.

6) Meetings with stakeholder groups representing municipalities, regions, and First Nation and Metis people.

7) During the course of the project the Review Committee also had ongoing discussions with the Advisory Committee to the External Review Committee. The list of Advisory Committee members and its terms of reference are in Appendix 13.

8) Requests for public input through media announcements and newspaper advertisements (Appendix 2).

9) Follow-up consultation meetings with the board chair and CEO of each of the RHAs.

Table 1.2 shows the number of requests for input and the response results from the requests for public input.

Table 1.2: Summary of Response to Request for Public Input

Target Group	Method	Requests Sent	Responses
General Public	Public notices	2 newspaper notices in 27 publications	135
Non-devolved hospitals and PCHs	Questionnaire	72	23
Key external stakeholder groups and organizations (Includes First Nation and Metis stakeholders.)	Letter requesting input	52	17
RHA and facility managers	Online survey	548	352
RHA board members	Online survey	116	82
RHA Community/District Health Advisory Council members	Online survey	144	120
Manitoba Health and Healthy Living senior managers	Letter requesting input	44	3

Early in the process, the Committee met with RHA board chairs and chief executive officers (CEOs) in a group session to gather their initial thoughts on the review and consult with them on the work plan. Subsequently, each RHA received a questionnaire with 48 questions to be answered in their written submission. (For the questionnaire, see Appendix 3). Following the receipt and analysis of the RHAs'

written submissions, the Committee met with the chair and CEO of each RHA to discuss their responses to the questionnaire and obtain additional input.

The surveys of board members, RHA managers and facility managers, and the members of Community/District Health Advisory Councils, were sent by email or hard copy if there was no email address. Seventy-three percent of the emailed invitations to participate were opened, and eighty per cent of those who opened the email responded. All of the surveys provided the opportunity for the respondents to give written comments as well.

Use of external resources

External consulting organizations were used for two elements of the work plan. SEQUUS International assisted in the design and administration of the online surveys. The Hay Group Health Care Consulting assisted in selection, examination and interpretation of pre-existing performance measures used in the Committee's assessment of the performance of the RHA system.

The Committee also made use of the services of a research assistant, Mr. Russell Burton, and an editor, Mr. Doug Smith.

The organization of this report

For purposes of the work plan, the Committee sub-divided the terms of reference into topic areas to be reviewed. This process allowed the Committee to investigate the various components that determine the effectiveness of regionalization. Summary judgments on various aspects of the terms of reference are presented throughout the report, and the Committee's recommendations are listed under the sub-section headings following the explanatory text. Because regionalization is a system, some of the recommendations have relevance to more than one section but are contained in the section with the greatest relevance. Throughout the body of the report, the Review Committee has highlighted, as examples, a number of best practices that have been adopted by individual RHAs. A more complete inventory of best practices in Manitoba RHAs has been compiled in a separate document.

The recommendations

In developing the recommendations, the Review Committee has focused on providing the "why" of the recommendations, the "what," (that is, what should be done), and, to the extent possible, the "how." In some instances, prescribing the "how" required information and data beyond the scope of this review. Finally, there is much to be said for the value of Manitoba Health and Healthy Living and the regions working together to develop the "how." Acceptance of change is best achieved by collaborative methods, not through the consultants' (or Manitoba Health and Healthy Living's) prescriptive solutions. For example, in the section on Community

Development, while the Committee learned of some innovative methods being used in the regions, it is not making a blanket recommendation that they be adopted by all RHAs. The Committee believes the outcomes will be more effective if each region decides for itself how best to obtain community input and has, therefore, only provided some principles to be followed.

2. Comparison with Regionalization in Other Provinces

In comparing regionalization in Manitoba with regionalization in other provinces, the Review Committee examined documented analysis on regionalization, particularly those studies and papers that addressed regional structures in all provinces. The purpose here is not to describe in detail all of the research, but to present overall conclusions that are relevant to this review of regionalization in Manitoba and the Review Committee's terms of reference.

Although regionalization has been implemented in all provinces, the year of implementation, the process of implementation and the structure of the regional system have varied widely. Despite the fact that provinces implemented regionalization for essentially the same reasons, no two jurisdictions have an identical system of regionalization. This is partly explained by the major differences between provinces. For example, regionalization in a province of ten million people will be different from regionalization in a province of one million people. Each regionalization model reflects the unique set of circumstances in that province.

The differences in regionalization between the provinces and lack of empirical data have prevented researchers from evaluating the overall effectiveness of regionalization. Two researchers have noted:

> Little has been done in most jurisdictions to evaluate the success of regionalization. There is little empirical measurement or evaluation of whether the expected outcomes of devolution/regionalization, as identified in stated rationales, were achieved. Also lacking is similar information about the implementation process itself – the success of various governance and accountability structures, funding mechanisms, management and delivery systems units of devolution, and planning activities. Most provinces are learning as they go but many have experienced difficulties in controlling runaway costs ...[2]

As noted above, the objectives of regionalization have been relatively common to all provinces. Most often they were:

- Cost reduction
- Better integration of services
- Improved system planning
- Increased public participation and ownership
- Improved governance
- Improved quality of care
- Improved focus on wellness and prevention
- Better accountability

The potential impact of regionalization is compromised when these often-competing objectives are not prioritized or when there is no monitoring or follow through for achieving the objectives. Effective planning and decision-making become difficult without clear goals and performance targets, leaving the system more vulnerable to external influences as *ad hoc* decisions are made in response to the issue of the day.

The barriers to more effective regionalization, which are reasonably common across the provinces, include:

- Lack of devolution of authority to the regions
- Political interference in the management of the region

2 Peggy Leatt, Beverley Nickoloff, Managing Change: Implications of Current Health Reforms on the Hospital Sector (An Ontario Hospital Association Discussion Paper, 2001) p. 41.

- Unclear priorities within the objectives of regionalization
- Potential for alienation of local communities

Although the degree of success has varied from province to province, it is generally agreed that regionalization in Canada has achieved the following:

- Less fragmentation in the system
- Less duplication of services in hospitals
- More partnerships developed

Based upon the experience with regionalization in Canada, the following statements have general support and should guide the Manitoba government's policy development as Manitoba strives to achieve the full benefits if regionalization.

- Regionalization is enhanced when regions have responsibility for the complete service continuum
- Governments should devolve authority to the regions and minimize political interference
- Prioritization of the objectives of regionalization by government is necessary to maximize the benefits of regionalization
- The need for buy-in by the professions, particularly doctors and nurses, must be recognized in designing changes to regionalization
- Effective community development processes are essential to ensure support for meaningful change

On balance, the experience of regionalization in Manitoba is not unlike that in other provinces. The unique characteristics of Manitoba have resulted in a "different" model of regionalization, but the problems and opportunities facing regionalization in Manitoba are largely the same as in other provinces.

3. Overall Assessment of Regionalization

This section provides the Committee's overall assessment of the effectiveness of regionalization in Manitoba. In answering the question "Has regionalization been effective?" it is necessary to address two separate questions. The first question is "How well has it worked compared to pre-regionalization?" and the second question is "How well has it worked in relation to what it was designed to achieve?"

Regarding the first question, it is not possible to rigorously compare Manitoba's regionalized health service system today with the system prior to regionalization for a variety of reasons. First, comparative data is not available for many factors simply because either the information was not collected prior to regionalization or it was collected in ways that do not allow for comparison. Second, since the number and complexity of services delivered today is significantly greater than ten years ago, many comparisons would in reality be "apples and oranges" comparisons. Third, even though there have been improvements in the delivery of health care to Manitobans, it is not possible to determine specifically how much of this improvement has been caused by regionalization. Because of changes in the system and lack of consistent measures over the ten-year period, causality cannot be determined.

The second question assesses regionalization in relation to what it was designed to achieve. The government proposed the following as the advantages or goals of regionalization:[3]

- Linking prevention, population health and treatment into a seamless continuum of care
- Evidence-based decision-making
- Broader base for service planning and delivery
- Enhanced consumer choice and involvement
- Physician recruitment
- Getting government out of service delivery
- More efficient, effective service delivery

As discussed in this report, the Committee is confident that, to varying degrees, the benefits listed above have been achieved. There are specific aspects of regionalization that have allowed progress to be made in each of these areas, although there are still opportunities for further improvement in all areas. However, a continuation of current efforts using existing systems and structures can produce only marginal improvements. "Working harder" is not the answer. To "take regionalization to the next level," it is the Committee's view that some fundamental changes to systems and structures are required. These changes are detailed in its recommendations.

The literature on change strategies in the health-care system is clear on the need to engage the health-care professions in the process. Many of the opportunities for improving regionalization depend upon the collaboration and support of the key stakeholders in the system. The Review Committee believes that getting the health-care professions on board, especially the physicians and nurses, should be a central focus in managing the change process.

Community ownership of health-care decisions and outcomes is important for the success of regionalization. It is obvious that choices will have to be made in the regions regarding priorities and allocation of resources. The long-held view in communities that "proximity equals quality" is no longer true and changes will have to be made if regionalization is to reach its potential. To be sure, the impact of the presence of specific health-care facilities and services in communities is a complex issue. There are economic, social and status issues involved. But to the extent that existing resources need to be re-deployed to better serve the health-care needs of

3 Manitoba Health and Healthy Living.

Manitobans, the key to change lies in empowered communities taking ownership of the issues. The present system of District/Community Health Advisory Councils (which are described in Section 10) works well in some regions and not so well in others. Part of the success today of regionalization is due to the focus on community input, and this will be a critical factor in moving regionalization forward.

Although the Committee did not see any merit to ranking its recommendations in order of importance, it is of the view that a major barrier to improvement is *the lack of target setting for regionalization using valid and reliable performance indicators.* The way to improve accountability between the RHAs, Manitoba Health and Healthy Living and the public is to use valid information on efficiency, costs and outcomes to set performance targets. The basic management principle "If you can't measure it, you can't manage it," is relevant to health services. Indeed, the fact that the system spends $3.6 billion of provincial funds annually but has not developed performance targets for common measures of efficiency, costs and outcomes is a critical issue that needs to be addressed. Moreover, as noted in Section 4 (Performance Measures), comparability of information between regions and between provinces is problematic because of socio-demographic differences and inconsistencies in the data available.

The existing limitations in measuring critical costs and outcomes prevent evidence-based changes from occurring. For example, volume-based funding, a strategy often recommended as a method of reducing wait times and encouraging cost reductions, is hindered if costing standards and measures are not developed. Similarly, a regional funding model that includes performance effectiveness as one of the accountability systems cannot be implemented without agreed measures of outcomes. Finally, accountability in any part of the system is weakened when some of the fundamental drivers of costs cannot be measured and benchmarked.

Equally problematic is the inability of health-service systems, both provincially and nationally, to provide patient information on a complete and timely basis. Lack of an effective electronic patient-record system inhibits the seamless transition of patients from region to region (indeed, from provider to provider within the same region!), reductions in duplication of effort in gathering patient information, and reductions in the risk of patient safety problems associated with incomplete patient information records.

The Review Committee acknowledges that these problems are not unique to Manitoba or to regionalization. The government has made progress in implementing information technology and outcomes measurement and is currently working on new projects. Also, it is acknowledged that health services are complex and present unique measurement and privacy issues not encountered by other kinds of organizations. Nevertheless, in view of the huge impact that improvements in these areas could have on efficiency and health outcomes, progress has been slow. This report notes that expenditures on information technology in Manitoba have

lagged behind other provinces but are now increasing. Effective information systems and databases for decision-making are critical for improving the effectiveness of regionalization.

The issue of "value for money" is complex and subjective. If the critical costs and outcomes of the system cannot be measured, attempting to determine value for money is little more than guesswork. For example, the fact that Manitoba spends more than the Canadian average per capita on health care may not, in itself, mean Manitobans are not getting value for their money. Since provincial outcomes are based upon regional outcomes, targeting the health-care needs of the regions and ensuring that health-care dollars are targeted at evidence-based opportunities is likely an effective strategy for improving the value for money.

The Review Committee's overall assessment is that regionalization of health care has been positive with benefits for Manitobans that probably would not otherwise have occurred. The system has strengths and many "best practices" have been implemented in the regions. There are also areas in which the regional system could be improved and these are presented in this report.

4. Performance Measures

The Review Committee was mandated to examine effectiveness and outcomes; clinical and operational efficiency; the match between service capacity and patient needs; and the integration of care across the continuum. The Review Committee used quantitative performance measures to assess the regional health system's effectiveness and efficiency and to compare its performance with other Canadian health systems.

In measuring the performance of a system it is important to consider both inputs and outputs. Inputs are the resources used to achieve the desired results (outputs). The relationship between inputs and outputs is a general measure of efficiency in a system, although causality is difficult to determine in a complex system such as health care. Inputs can be valued on their own merit without reference to outputs. For example, a 2007 report from the Canadian Institute for Health Information (CIHI) entitled *Drug Expenditures in Canada* reports that Manitoba's Pharmacare program has the highest provincial coverage in Canada, paying 54% of prescription drug expenditures for Manitobans. Also, the 2007 CIHI report on *Home Care Spending* indicates that Manitoba home-care spending is higher than nearly every other province. These can be valued inputs for any number of reasons, but how these inputs affect health-care outcomes, socio-economic outcomes or personal satisfaction outcomes needs additional study. In this report, the Committee is conscious of the complex relationship between inputs and outputs and that causality must be inferred with caution.

With the assistance of Hay Group Health Care Consulting, the Review Committee compiled a range of pre-existing performance measures at the national, provincial and regional levels. The measures were selected on the basis of the following criteria, namely whether they were:

- Measured in Manitoba
- Measured in other provinces in a manner that enables meaningful inter-provincial comparisons
- Reasonably adjusted for factors such as socio-demographics

Inter-provincial comparisons at the RHA level were done using a peer grouping methodology developed by Statistics Canada. The methodology is based on 24 variables, including basic demographics, living conditions and working conditions. In the Review Committee's meetings with the RHAs, discussions were held about how individual RHAs were performing in comparison with comparable regions from across Canada, what measures were being taken to address areas of under performance and performance trends.

This section is a scorecard on overall system performance for the Province of Manitoba. Unlike at the RHA level, where peer groups from other provinces are available, there is no perfect peer province against which Manitoba's performance can be compared. Although age and gender mix adjustments can be obtained for many indicators, there are very few pre-existing performance indicators available that have adjustments for factors such as socio-demographic conditions. This is a significant omission as the recent research done by the Manitoba Centre for Health Policy on population-based funding methodologies shows that socio-demographic factors, such as unemployment rates and education levels, have a significant impact on health status and the use of health services. Socio-demographic factors are beyond the control of the RHAs and even beyond the control of Manitoba Health and Healthy Living. There are also other factors such as the size of the province, population distribution and the health status of the Aboriginal population. Therefore, the indicator comparisons presented here should be interpreted with caution when considering how well the regional health system has performed.

Many of the indicators shown in this section are drawn from the *Comparable Indicator Report* that Manitoba Health and Healthy Living published in November 2004. The data used here is more current than in that report. Also, additional indicators are provided here to give a balance of financial and non-financial performance. *The Manitoba Comparable Indicator Report* does not provide an explanation as to why performance in Manitoba varies from Canada on key

performance indicators and neither does this report, as this determination was beyond the Committee's terms of reference.

The indicators were selected from the following five domains:

- Health status
- Maintaining health
- Access
- Satisfaction
- Expenditures

As stated earlier in this report the government of Manitoba proposed the following as the advantages or goals of regionalization:

- Linking prevention, population health and treatment into a seamless continuum of care
- Evidence-based decision-making
- Broader base for service planning and delivery
- Enhanced consumer choice and involvement
- Physician recruitment
- Getting government out of service delivery
- More efficient, effective service delivery

The indicators in this section of the report are particularly relevant in showing whether there has been success in Manitoba in achieving goal 1 (linking prevention, population health and treatment into a seamless continuum of care), goal 5 (physician recruitment) and goal 7 (more efficient, effective service delivery).

Some of the indicators are based on results for the entire population, while others are based on surveys of a sample of the entire population. In the cases of samples of the entire population, statistical testing was needed to determine whether differences in reported values were statistically significant or if there was essentially no difference. In other words, while the value on an indicator might be larger or smaller for Manitoba than for Canada, the statistical testing tells us whether, with some level of certainty, there really is a difference. Manitoba Health and Healthy Living statisticians have provided us with this statistical analysis.

Health status

Health status is an indication of the outcomes of the conditions and behaviors that promote good health. Five health status indicators are presented here. These indicators are listed below including the year for which the most recent data is available.

- Per cent of low birth-weight babies (2003)
- Percent of population with fair or poor self-rated health (2005)
- Infant mortality per 1,000 live births (2003)
- Life expectancy at birth (2004)
- Potential years of life lost rate per 100,000 population for all causes of death (2001)

Manitoba performs better than Canada on the indicator for low birth-weight babies. The percentage of low birth-weight babies in Manitoba is 5.5% versus 5.9% for Canada.

In Manitoba, 11.4% of the population has fair or poor self-rated health versus 11.7% for Canada. There is not a statistically significant difference on this indicator between the results for Manitoba and Canada.

Manitoba does not perform as well as Canada on three of these *Health status* performance indicators: infant mortality rate of 8.0 per 1,000 live births in Manitoba versus 5.3 in Canada; life expectancy at birth of 78.9 years in Manitoba versus 80.2 years in Canada; and 6,106 potential years of life lost from all causes of death per 100,000 population in Manitoba versus 5,102 in Canada.

Information on trends in Manitoba was available for two of these indicators. Infant mortality in Manitoba per 1,000 live births increased from 7.0 in 1997 to 8.0 in 2003. Life expectancy at birth in Manitoba increased between 1997 and 2004 from 77.9 to 78.9 years of age.

Maintaining health

Indicators related to *Maintaining health* provide information on how the manner in which we live our lives potentially impacts on our health. The following seven indicators related to *Maintaining health* are presented here:

- Per cent of population current daily/occasional smokers (2005)
- Per cent of population that is obese. Obesity was defined as having a body mass index (BMI) of greater than 30 (2005)

- Age standardized hospitalization rate due to injury per 100,000 population (2005)
- Per cent of population that is physically inactive (2005)
- Teen pregnancy rate per 1,000 females 15 to 19 years old (2003)
- Per cent of population with no mammogram for at least 2 years (2005)
- Per cent of population having had a pap smear 3 or more years ago (2005)

There is no statistically significant difference in performance between Manitoba and Canada on the following three indicators:

- 20.4% of population in Manitoba are current or daily occasional smokers versus 21.7% for Canada
- 32.7% of population with no mammogram for at least 2 years in Manitoba versus 27.4% in Canada
- 14.3% of population having a pap smear 3 or more years ago in Manitoba versus 13.5% in Canada

Manitoba does not perform as well as Canada on the following indicators:

- 18.1% of the population is obese in Manitoba versus 15.5% in Canada
- Age standardized hospitalization rate due to injury per 100,000 population is 672 in Manitoba versus 543 in Canada
- 50.2% of population physically inactive in Manitoba versus 46.7% in Canada
- Teen pregnancy rate of 53.4 per 1,000 females 15 to 19 years old in Manitoba versus 32.1 in Canada

The percentage of the Manitoba population that smokes on a daily or occasional basis fell from 25% in 2000 to 20.4% in 2005. The percentage of the Manitoba population that is obese remained essentially the same between 2000 and 2005. The Manitoba age standardized hospitalization rate due to injury per 100,000 population fell from 735 in 1999 to 672 in 2005.

Access

Access indicators provide information on the ease with which the public can obtain services from the health-services system. Two indicators are presented below.

- Per cent of population without regular medical doctor (2005)
- Age standardized acute care hospitalization rate per 100,000 people for conditions where outpatient care prevents or reduces need for admission to hospital (2005). This is seen as an indicator of the number of hospitalizations that could potentially have been prevented if there were greater access to outpatient care.

There is not a statistically significant difference on the indicator for population without a regular medical doctor. Sixteen per cent of the Manitoba population is without a regular medical doctor versus 14.3% for Canada.

Manitoba does not perform as well as Canada on the indicator of age standardized acute care hospitalization rate for conditions where outpatient care prevents or reduces need for admission to hospital. The rate is 454 admissions per 100,000 people in Manitoba versus 389 in Canada. However, it appears that access to appropriate outpatient care has improved in Manitoba between 1997 and 2005, as potentially unnecessary hospital admissions have reduced from 570 to 454 per 100,000 people.

Satisfaction

The Review Committee chose percentage of the population that rates health services received as excellent or good to measure performance in the *Satisfaction* domain.

There is not a statistically significant difference on this indicator. Eighty-seven per cent of the population in Manitoba in 2005 rated health services received as excellent or good versus 85.2% for Canada.

Expenditures

For *Expenditure* performance indicators, the Review Committee selected Manitoba Government expenditures per capita adjusted for the gender and age mix of the population of Manitoba as compared to Canada. Manitoba Government rather than public-sector expenses were used because Manitoba public-sector expenditures are affected by the federal government direct expenditures for the high percent of First Nations people in Manitoba compared to Canada as a whole. The indicators provide a forecast of 2006/2007 expenditures from CIHI based on actual data from 2004/2005. CIHI does not routinely adjust for age and gender mix when it issues these numbers annually. Therefore, the Review Committee applied adjustment

factors for Manitoba developed by CIHI using 2002 data included in a special report that CIHI published in 2005.[4] This adjustment is important for this comparison, since Manitoba has an older population than Canada as a whole. In addition to the age- and gender-mix adjustments, the CIHI adjustment also standardizes physician expenditures for the different fee levels in each province. The effect of these adjustments is to reduce the relative expenditure rates for Manitoba from what they would be without the adjustments.

The expenditure indicators are as follows:

- Total Provincial Government expenditures per capita (2006/07)
- Hospital expenditures per capita (2006/07)
- Other Institutions expenditures per capita (2006/07)
- Physician expenditures per capita (2006/07)

The Manitoba Government spends at about the same rate as Canada on the Hospital category. The rate is $1,297 per capita in Manitoba versus $1,232 for Canada.

The Manitoba Government spends more per capita than Canada on the following measures: total Provincial Government expenditures are $3,563 per capita in Manitoba versus $3,196 for Canada; Other Institutions expenditures are $409 per capita in Manitoba versus $308 for Canada; and Physicians expenditures are $630 per capita in Manitoba versus $589 for Canada.

Although Manitoba spends more than the Canadian average per capita on health care, Manitoba's health-system performance related to the measures the Review Committee has selected may not reflect a comparative benefit from this additional spending. This could mean that money is not being allocated appropriately to maximize performance, that the structures and processes being used in Manitoba are not as effective as they could be, that demographic and socio-economic factors of the Manitoba population affect the health outcomes or a combination of all of the above.

The Review Committee recognizes that selecting indicators for performance comparisons is a somewhat arbitrary process and causal relationships are complex. Nevertheless, the Review Committee believes, that the indicators presented above provide a reasonably balanced perspective on health-system performance in Manitoba. Moreover, they provide some context to the Review Committee's observations and recommendations in this report, particularly as they relate to the achievement of Manitoba's regionalization goals including linking prevention,

4 Canadian Institute for Health Information, *Provincial and Territorial Government Health Expenditure by Age Group, Sex and Major Category: Recent and Future Growth Rates*, Ottawa: Canadian Institute for Health Information, May 2005.

population health and treatment into a seamless continuum of care, physician recruitment, and more efficient, effective service delivery. At a minimum, this set of indicators suggests the need for evidence-based decision-making in deciding what inputs should be applied in which areas to achieve desired outputs.

5. Major Accomplishments of Regionalization

As the Review Committee has already noted, the regionalization of health care has, on the whole, been a positive development that has provided Manitobans with a variety of health-care benefits that may not have been available in its absence. During the consultative process, the Regional Health Authorities identified many regional and provincial accomplishments in the last 10 years. For example, regionalization has provided RHAs with the ability to:

- Establish Primary Care Centres that reflect the needs of the population in a specific district or community. There is room for further growth in this area.
- Develop standards of care throughout the region and implement provincial standards.
- Structure programs and services using a population-health approach.
- Improve the delivery of Emergency Medical Services (EMS).
- Develop partnerships and work in collaboration with other agencies such as family service agencies, education authorities and municipalities.

- Establish chronic disease prevention and management programs depending on the needs of the population. These include programs such as In Motion, Heart Healthy Living and Getting Better Together.
- Implement cervical and breast screening programs.
- Increase support to seniors' programs within the regions.
- Develop relationships with the various First Nation communities in each region to better address their health needs and understand their cultures.
- Facilitate community involvement and participation in health initiatives within the regions.
- Participate in the processes of the Canadian Council for Health Services Accreditation (CCHSA) to obtain accreditation on a region-wide basis.
- Create Centres of Excellence within some regions and Regional Health Centres in others, to ensure competency and skill levels for safe patient care. The Health Centre concept offers a wide range of integrated programs and services in one location.
- Expand midwifery into several regions, with room for growth.
- Expand radiology service capacity by enabling the electronic communication of medical images.
- Increase centralized purchasing within the regions and provincially to assist in cost reduction of supplies.
- Improve patient assessment and placement to facilitate the linkages between health-service delivery providers.
- Implement regional strategies for the retention and recruitment of health-services human resources.

While not exhaustive, this list does give a sense of the kinds of significant initiatives being undertaken by the RHAs and Manitoba Health and Healthy Living. While all of these initiatives are a work in progress, they demonstrate the coordination and cooperation facilitated by regionalization. The RHAs and Manitoba Health and Healthy Living are continuously working with their partners to attempt to make improvements in each of these areas and others.

Through the consultation process, it was evident that the integration of services across regional boundaries has been necessary in order to provide the services required. The RHAs indicated that the process for integrating services between RHAs was collaborative, relatively seamless and effective since the inception of regionalization. In this respect, regionalization has enhanced the ability of each RHA to collaborate with each other and Manitoba Health and Healthy Living on behalf of its respective community. RHAs stated that regionalization has improved the communication, networking and ultimately the integration of services within and between RHAs.

While some variation exists between the boundaries for family service agencies, educational authorities, and municipalities and RHA boundaries, the RHAs stated that these differences did not pose a barrier to effective collaboration and partnerships with these groups.

Regionalization is evolving and will continue to evolve. The RHAs identified that stability of RHA boundaries is required in order to develop a rapport with communities and to achieve functional improvements during the next few years, given the challenges with geographic areas and a diverse population. As regionalization evolves, the advantages of a larger population base that enhances shared scarce resources provides a broader base to establish specialty services and allows capital planning to be optimized, which may encourage further amalgamation.

6. ACCOUNTABILITY

Accountability is the critical link that can tie governance, management and performance into an effective service-delivery mechanism. The Review Committee's review of accountability addressed accountability of board members, accountability of boards to the public and patients, accountability of the RHAs to Manitoba Health and Healthy Living, accountability of CEOs to regional boards and accountability of managers to CEOs.

The concept of accountability in the RHA system is unique in several respects, making comparison with more traditional organizations problematic. While the provincial government has delegated formal authority to the RHAs, they (the government) are also under an obligation to answer to the stakeholders in the region. As a result, RHAs are often faced with conflicting accountability demands. The situation is complicated by the inherently political nature of health care, which can result in evidence-based decisions being set aside in response to political priorities. The fact that elected officials are accountable to their constituents can also lead to different decisions than those preferred by RHA management. The result is that accountability in the system tends to be more focused on processes rather than outcomes. In general, the Review Committee is recommending that the accountability system should increase its emphasis on outcomes.

Fundamental to accountability is (1) clarity of roles, (2) consistent and transparent processes to implement accountability, (3) measurable standards or expectations of performance and (4) clear consequences for performance that is above or below expectations. It is within this framework that the Committee examined accountability in the regionalization of health services. The Review Committee does not subscribe to the view that "increased accountability processes are always

desirable." Accountability must always be viewed in the context of risk and reward and whether accountability processes are focused on the right outcomes. There is tremendous pressure for more accountability in health services, often without the understanding that more is not necessarily better.

The Review Committee did not conduct an in-depth review of financial controls. These financial control processes in each RHA are reviewed regularly by external, independent auditors and improvements implemented when necessary. The Review Committee has no reason to believe that the financial controls in the regional system are lacking. This is not to say that the existing financial controls necessarily enhance the delivery of health services, since some of the financial controls are focused on relatively insignificant (but high profile) factors (such as travel expenses and cell-phone costs) rather than the larger issue of total value for money.

The Review Committee is also of the view that media and public attention paid to the few incidents of misuse of government funds has helped foster an abnormal emphasis on decisions that have a low impact on the real accountability that should be driving the system. It is important, therefore, that improvements in accountability focus on the primary drivers of effective and efficient delivery of health services.

There are several opportunities to improve accountability in the regional health system. Manitoba Health and Health Living is currently working on a new accountability framework that may address these issues. The Review Committee believes that if the requisite system-wide accountability processes proposed in this report are implemented, the delivery of health services in the RHAs will be more effective.

Devolution of authority

The effectiveness of regionalization can potentially be improved if decision-making authority in the RHAs is expanded to give CEOs and boards more control over the health-services outcomes in their RHA. Although centralized management of some aspects of regionalization is desirable (for example, information technology), decisions that impact directly on health outcomes in the RHAs are best left to the RHAs. However, for increased devolution to be effective, it must be tied to regional accountability. In other words, the relationship between regional health assessments, strategic plans, health plans and annual budgets must be placed into a clear accountability framework. This framework would focus on health-services outcomes that can be reasonably influenced by RHA CEO and board decisions as part of the accountability processes. Once standards, measurements and expectations (targets) are established for each RHA, Manitoba Health and Healthy Living, patients and the public can effectively hold the RHA accountable for its performance.

The Review Committee recognizes that only emphasizing quantifiable outcomes has the potential to create perverse behaviors, in that the RHAs, in their attempts

to achieve outcomes, would be obliged to pay less attention to the processes used to achieve those outcomes. Therefore, it is important to report on and monitor processes as well. The Review Committee's proposed changes would place a stronger emphasis on regional outcomes while retaining a focus on the processes used to achieve those outcomes.

Clarity of roles and authority and agreement on outcome measures enhance the accountability process. The original rationale for regionalization was to minimize the government's involvement in direct service delivery on the premise that a regional governance and management system would be more effective at delivering the services. There was a clear role for the regions (service planning and delivery) and a clear role for the government. Briefly, the role of government was confined primarily to setting standards, program monitoring, establishing benchmarks and evaluating and auditing fiscal accountability measures. The government plays an important role in setting provincial priorities, centralizing some administrative services, and planning for critical province-wide resource needs such as long-term human resource needs, capital planning and information and communication technology requirements.

The Review Committee's view is that since the implementation of regionalization, the distinction between the role of the RHAs and the role of government has become less clear as the government has assumed more of the responsibility for decisions in the regions. The feedback from the RHAs was that the major decisions, such as the types and capacities of services that will be provided in each community, are made by government, leaving the less consequential (and less controversial) decisions to the RHAs. If regionalization is to achieve its maximum potential, increased devolution of decision-making authority to the regions must occur. However, the devolution can only be effective if proper accountability processes are implemented as well. In other words, increased authority in the RHAs must be accompanied by increased accountability.

Increased accountability in the RHAs involves increased accountability for board chairs, CEOs and their management organization and for board members. The specifics of how this can be done are detailed in several sections of this report.

Authority in any organization is delegated within limits. Discretion (authority) can never be unbounded. It is also true that the wider the limits, the greater the empowerment of decision-makers. Effective delegation requires clear and consistent limits to authority. Inconsistent application of limits has the effect of reducing the limits to a narrow range in which decision-makers will only make risk-free decisions. The Review Committee's recommendation relates to implementing greater empowerment of the RHAs by increasing the delegation of authority.

Recommendation

6.1 Manitoba Health and Healthy Living should increase the devolution of authority to Regional Health Authorities, along with a commensurate increase in accountability. The increased devolution of authority should allow Regional Health Authorities to make critical resource allocation and service planning decisions that impact quality and the availability of health services in the regions.

Empowering the RHAs: A process for change

Perhaps the most dominant theme to emerge through the Committee's review was the sense, on the part of the RHAs, that they were not empowered to implement meaningful change (which is addressed in recommendation 6.1). In the Committee's view, some RHAs are prepared to implement significant changes but are powerless to do so. As noted above, if left unchanged, this situation would impede the government's ability to implement accountability in the RHAs.

The Review Committee is also sensitive to the complexity of the interface between the political system and the managerial system in delivering health services. Decisions regarding health services are arguably the highest profile of all of the decisions that governments make. What is needed, therefore, is a decision-making protocol that respects the political sensitivity of health-services issues, but allows the RHAs to make decisions with clear accountability. One of the original objectives of regionalization was to increase opportunities to reduce duplication and overlap through rationalized service delivery using community-based consultation processes. It follows, therefore, that if there is clear community support for changes in local services (and the RHA is held accountable for establishing that support and for the resulting outcomes), the intent of the legislation is being implemented.

The Review Committee is not in a position to recommend specifically what the decision-making protocol should be, except as noted above, the authority should be clear, consistent and as broad as possible. The development of such a protocol is critical to implementing improvements in the regional health system. As noted above, if RHAs cannot have the authority (within reasonable and clear limits) to manage their resources, there cannot be meaningful accountability for outcomes.

Recommendation

6.2 Manitoba Health and Healthy Living, in consultation with the Regional Health Authorities, should develop an evidence-based decision-making protocol for implementing changes in the use of regional resources. This protocol should provide guidance to the Regional Health Authorities

regarding methodologies for maximizing the probability of government support for service delivery changes.

RHA accountability processes

The four principles of accountability listed previously are excellent guides to increasing accountability within the regional health system. With increased devolution of decision-making relating to health-services outcomes, RHAs can—and should—be held more accountable for health outcomes in their regions. Clearly defined outcome measures on matters that the RHA can affect, transparency in establishing the outcomes and measures of performance, and clear and ongoing feedback, particularly on proposals for new initiatives in annual health plans, will lay the foundation for a more effective accountability system.

Measures, expectations and targets can be different for different regions. Indeed, one of the purposes of regionalization was to allow for unique differences between the regions. Although the process for establishing standards, performance measures and targets will be common for all of the regions, the accountability system must allow for regional differences.

Recommendation

6.3 Manitoba Health and Healthy Living, in consultation with the Regional Health Authorities, should establish clear and transparent processes to provide regular and clear feedback to Regional Health Authorities on their performance measures.

7. GOVERNANCE OF RHAs

The Review Committee notes that the Auditor General of Manitoba conducted a review of governance practices in the RHAs in 2002. Although the Auditor General's report did not make specific recommendations, the Review Committee found that, although some changes have been made, many of the issues identified by the Auditor General remain. These are dealt with in the recommendations in this report.

Most of the RHA boards employ a governance model based on the Carver governance principles, which focus on the ends (the goals to be achieved) and the policy framework as set out by the board, leaving the means (how to achieve the goals) to the CEO and the managers within the regional structure. The model is well-suited for the governance of the RHAs, since the boards are primarily composed of lay individuals without health-services backgrounds. The effectiveness of the model depends substantially upon the chair's ability and willingness to follow the model and keep board members focused on the policy governance framework and strategic planning, rather than on the operational issues of the RHA. Thus, the role of the board chair is critical to effective governance and accountability.

Board members are provided a substantial amount of information to assist them in performing their duties. Although the amount and type of information provided varies from region to region, in general, board members are well-informed about issues in the region and receive training for their role.

Transparency in board appointments

The Minister of Health appoints all RHA board members. The *Act* gives the Minister considerable discretion in soliciting candidates and making the final selection. While the legislation provides for the possibility of elected boards members, the review found little support for this in the regions, where the feeling is that having elected board members would be divisive and politicize the provision of health services.

In its efforts to enhance accountability in the regional health system, the Review Committee has focused on several factors that can inhibit an RHA board's effectiveness and accountability. First, the current appointment process does not allow for ensuring that boards have a proper mix of skills. Second, there are minimal published selection criteria or candidate qualifications. Third, the government sometimes appoints board members without consulting with either the RHA board chair or CEO. Fourth, there is no succession planning for replacement of board members. Fifth, while RHA Boards are accountable to the Minister of Health, there is no formal accountability process to hold individual board members and boards in general accountable to either the region or to the Minister.

The net effect is a lack of transparency in governance processes, which leads ultimately to reduced board accountability. For example, while Ministers have removed ineffective board members in some circumstances, the Review Committee was told of other situations in which an ineffective board member or chair remained in place for years. In situations where an RHA might be underperforming, there does not appear to be a transparent process in place to hold the board members accountable.

Clarity of roles

Clarity as to the role of board members is also important for accountability. The Carver model is clear in its definition of the role of a board member as one of governance, not representation. As noted earlier, RHA boards have a unique accountability relationship with the government and their stakeholders. Therefore, in practice there can be role conflict, depending upon the reasons for which an individual has been appointed. The Review Committee is aware that often board members are appointed, or perceive themselves to have been appointed, to represent certain interests or areas. Indeed, boards often request that the government appoint specific individuals to represent geographic areas or interest groups. The practice of good governance is compromised when board members are expected to occupy multiple roles, such as being representatives of geographical areas within a region or being representatives of particular interest groups. This mixing of the governance

role and the representative role makes measurement of board member performance difficult. Moreover, when communities or groups of individuals see board member "X" as their representative, they are more likely to bypass the existing District Health Advisory Councils or Community Health Advisory Councils[5] and try to influence the board through their representative on the board. This can undermine the District Health Advisory Councils or Community Health Advisory Councils, which are a more appropriate vehicle for community input. In sum, RHAs should be required to develop effective community participative and representation mechanisms *outside of the board* so that boards can focus on governance, fiduciary responsibilities and strategic planning.

Conflicts of interest can also occur in board appointments, although board conflict of interest policies (which exist in all RHAs) can deal with some of the potential conflicts. The Act prohibits the RHA CEO and "any person who provides professional advice to the Region" from being appointed to a RHA board. The Review Committee is of the view that improved governance would result if the following categories of individuals were also ineligible for appointments to an RHA board: employees who directly report to the CEO of the Region, elected officials of unions representing workers at the RHA, and elected government representatives.

Board effectiveness

Assessment of board effectiveness is important for board accountability. The process for assessing board effectiveness varies within the regions, but all RHAs use a form of self-assessment. This assessment is not shared with anyone outside of the board on a formal basis. Since transparency is paramount where public funds are involved, a more transparent and accountable process should be in place. As one possibility, an external, third-party assessment with the results shared with the board chair and Manitoba Health and Healthy Living would increase the accountability of boards and board members.

Effective boards are boards that add value to the work of the CEO. Each of the RHAs is responsible for the expenditure of millions of dollars and requires leadership and governance commensurate with that responsibility. For example, if the CEO is charged with the responsibility of executing a five-year strategic plan (as is the case with all RHAs), board members who have the ability to operate in five-year time horizons will add the most value to the CEO's work. In fact, a significant barrier to the effective use of the Carver model is a board that cannot function at the policy governance level. Therefore, the accountability of individual board members and boards is enhanced when the overall capability of the board is on par with the CEO.

5 These Councils are discussed in Section 10 – Planning.

The Review Committee notes that the stipend paid to board members and board chairs is sufficiently small to almost make them volunteers. Moreover, the stipend has not increased since the inception of regionalization. The volume of work is heavy and it is a significant time commitment for those willing to serve. The size of the expenditure budget for RHAs *and the increased accountability proposed* in this review would suggest that, given that board members are not volunteers, their remuneration should be at a level between the current amount and the corporate model. Increased remuneration would likely make RHA board positions more attractive to individuals with the desired skills and capability. This model could also allow for smaller boards since the requirement for the relatively large number of board members needed to represent special interests would be eliminated if the community input process is placed in a separate accountability framework (See Recommendations 10.1 and 10.2).

The RHAs offered several solutions to the transparency problem associated with board appointments: (a) board nominating committees; (b) required interviews for all candidates; (c) posting of minimum selection criteria; and (d) community-based nomination/selection processes that would forward a list of suitable candidates to a board nominating committee.

Recommendations

7.1 The Manitoba government should make the appointment of Regional Health Authority board members and chairs more consultative, rigorous and transparent. In consultation with the Regional Health Authorities, this process could include (a) board nominating committees; (b) required interviews for all candidates; (c) posting of minimum selection criteria; and (d) community-based nomination/selection processes that would forward a list of suitable candidates to a board nominating committee.

7.2 The following categories of individuals should be made ineligible for appointments to a Regional Health Authority board: employees who directly report to the chief executive officer of the Region, elected officials of unions representing workers at the Regional Health Authority, and elected government representatives.

7.3 Manitoba Health and Healthy Living, in consultation with the Regional Health Authorities, should develop processes to increase the accountability of boards and board members. The processes should include independent, third-party assessment of board and board member effectiveness, board accountability for empowering communities in the region, and meeting health care outcomes and service delivery objectives.

7.4 Remuneration of Regional Health Authority board members and chairs should be increased to reflect the increase in the cost of living from the time the stipends were originally established. If the authority, responsibility and accountability of Regional Health Authority boards are increased (as recommended in this review), external advice should be sought to evaluate the directors' new role and establish compensation benchmarks for directors on comparable boards.

Another dimension of governance and board accountability relates to performance. As noted elsewhere in this report, uniform performance data is not available to the RHAs. Although all RHAs report on their achievements to their boards, there is little consistency of reporting and measures. Manitoba Health and Healthy Living currently encourages RHAs to use an endorsed performance measurement framework that is primarily based on health status and the determinants of health. This has an insufficient focus on system outcomes and system efficiency. As a result, boards have only a general frame of reference for forming expectations. Also, much of the reporting is on means (processes), not ends (outcomes). It is difficult to enhance board accountability if there are no measures and targets, and no benchmarks with other RHAs. This is addressed by Recommendation 10.5 in Section 10 (Planning).

8. Human Resources

Human resource shortages

Human resource shortages were a consistent theme throughout all of the Committee's research and discussions with the RHAs. While the issue of physician shortages dominated, virtually all health-services staffing was of concern. Not all RHAs face the same staffing issues (although staff retention is common for all) and the areas of shortages differed between the RHAs.

Rural and northern RHAs generally have the greatest difficulty in hiring and retaining qualified staff. While there is a very high use of International Medical Graduates (IMGs) in these areas, their tenure tends to be the minimum time required for them to gain experience and meet their placement requirements. While communities are grateful for the services the IMGs provide, this "revolving door" of physician services is less than ideal.

The shortage of qualified staff is exacerbated by the demographics of the health-services workforce and high turnover, often due to the stresses of the job. In some RHAs, the demographics of the health-services workforce present serious challenges as more and more employees retire. In many of the RHAs, particularly in the rural and northern regions, constant staff turnover and shortages increase the stress and burnout. This, in turn, increases the recruitment and retention problems. The data from the Review Committee's management survey generally confirms this conclusion. In addition, the Review Committee was told on many occasions that, because of the

staffing issues described above, individuals were retiring earlier, were less interested in moving into managerial positions, were more prone to leave health services as a career and were less interested in entering a career in health services.

The shortage of qualified health-services staff is independent of the regionalization of health services. Indeed, the problems of recruitment and retention are common to many areas of the Canadian and Manitoba economies. Prior to regionalization, the human resource problem was fragmented into hundreds of boards and facilities, each one competing for its own interests. Regionalization has allowed the RHAs to bring more resources and specialized skills to focus on their region's unique human resource requirements and problems. In other words, the regionalization of health services has changed the underlying structure of the approach to human resource shortages by providing the opportunity for RHAs to direct resources to the problem areas.

In approaching issues of recruitment and retention, the RHAs (and the communities within those regions) have exhibited both creativity and commitment in taking responsibility for working toward solutions.[6] Many of these strategies have proven to be effective. RHAs are now offering more training opportunities in the regions and these have proven very successful in attracting and retaining locally qualified individuals. This "grow-our-own" strategy reduces the need for community residents to leave the region to receive training, education and certification and has had a measurable positive impact on the recruitment and retention of rural and northern health-services employees. In an example of a best practice, Assiniboine RHA offers web-based Emergency Medical Technician training that allows individuals to complete the training in the region. As always, there is opportunity for more to be done in all of the regions, but the "grow-our-own" strategy appears to be one of the most effective methods of dealing with recruitment and retention in many of the regions.

Other successful strategies include student sponsorships, mentoring programs, specific recruiting strategies targeted at Aboriginal people, community involvement in recruiting and local programs aimed at retaining IMGs by helping to integrate them into the region and into the communities. Although recruitment and retention problems still exist, the Committee believes that the problems would be substantially greater if these regional and community initiatives had not been undertaken.

Centralization and human resource strategies

The human resource issue is an excellent example of how regionalization and centralization need not be opposing approaches. The key is to clarify the roles and

6 As noted in the Community Involvement section of Section 10 (Planning), community ownership of health-services solutions is a critical strategy in increasing the effectiveness of regionalization. Involvement in recruitment and retention at the grassroots level is but one example of how communities can get involved.

responsibilities, and determine who is best suited to do what. The Physician Resource Coordinating Office of Manitoba Health and Healthy Living was singled out as an example of how centralization of the initial recruitment processes benefits all of the RHAs. Since not all RHAs have the resources and expertise required to effectively recruit their own primary care physicians and specialists, this central office serves a very important function. The role of the RHA, therefore, is oriented toward attracting the physician to the RHA and then providing support once the physician is in the community. The success experienced with this model could possibly be applied to other professional disciplines that offer health services.

A more centralized approach to human resource planning is recommended. A long-term strategic human resource plan would estimate the province's long-term needs for each health-care discipline, the available supply, where these disciplines are likely to be needed within the regions, the capacity in the province to provide the required training and education, and the costs associated with implementing the plan.

Centres of excellence and human resource strategies

Public expectations regarding health-service delivery also have an influence on human resource issues. While it may be the case that some would like "everything, offered everywhere," the concept of centres of excellence (or consolidation or specialization) can have a major positive impact on recruitment and retention of professional staff. Some of the factors that attract and retain professionals are the opportunity to practice in environments where they have a critical mass of colleagues, modern equipment accompanied by professional surroundings and workloads that provide the opportunity for a balanced life. Centres of excellence are an important factor in providing these conditions, since they attract individuals who share common interests, skills and values. RHAs and communities that do not provide these factors will continue to have difficulty recruiting and retaining physicians and other health-services professionals. To put it positively, communities and RHAs that are able to implement or enhance the centre-of-excellence concept and incorporate it into their recruitment and retention strategies will likely be more successful. As an example of a best practice in this area, Interlake RHA consolidated its regional surgical and obstetrical programs at Selkirk General Hospital to improve quality and patient safety, ensure staff expertise, improve staff retention and recruitment and improve cost effectiveness.

Volunteerism

Volunteers are an important element in health-services human resources. Traditionally, there has been a strong volunteer component in every area of the fundraising and delivery of health services. One of the challenges facing RHA boards at the time of regionalization was to ensure that volunteerism remained a significant

and viable component of the system. The concern was that local residents would see regionalization as weakening local control over health-services institutions and, as a result, cease to identify with and volunteer their support to those institutions. The Review Committee can report that all RHAs said this problem had not materialized and, in some instances, volunteerism has actually increased. If there is a concern with volunteerism, it is with the aging of the demographic cohort associated with it, not regionalization.

A representative workforce

The Review Committee examined the degree to which the demographics of each RHA's workforce was representative of the region's workforce, paying particular attention to the employment of Aboriginal people in the regional health-services system. This is important both for career opportunity purposes and for cultural reasons, since many Aboriginal people access the health-services system due to the gap between the health status of Aboriginal and the non-Aboriginal population of the province. Aboriginal people represent a large and rapidly growing labour pool for Manitoba and the shortage of qualified individuals in the health-services field presents a major employment opportunity. The RHAs have many unique programs to attract Aboriginal people into their workforce, some of which would constitute best practices. In an example of a best practice, the Brandon Regional Health Authority has created a partnership with Aboriginal groups. Through this partnership, specific programs inform Aboriginal people about careers in health care, increase cultural awareness within the region, operate Aboriginal staff circles and organize Elder visitations. A number of RHAs have identified an Aboriginal representative workforce strategy in their performance deliverables and many have signed partnership agreements with Manitoba Aboriginal and Northern Affairs. However, on a provincial level, efforts and outcomes are not systematic, targets for improvement are often not set and the performance of RHAs, although reported to Manitoba Health and Healthy Living, is not part of an accountability process.

Recommendations

8.1 Because of the proven success of the "grow-our-own" recruiting and retention strategies, Regional Health Authorities and Manitoba Health and Healthy Living should promote and support this as one of the primary recruiting and retention strategies.

8.2 Manitoba Health and Healthy Living should develop and implement a central long-term health-services human resource strategy for all health disciplines.

8.3 Manitoba Health and Healthy Living should implement regional accountability processes and appropriate targets for developing a workforce that reflects the Aboriginal demographics of the Regional Health Authorities.

9. Management and Organization

The specific focus of this part of the review was on the percentage of RHA budgets allocated to administrative costs, the impact of the focus on administrative costs on managerial authority and accountability, managing change and innovation and structural design. The methodology used a variety of sources for analysis. The Review Committee's analysis and recommendations are based on the overall pattern of data, not on responses from any particular RHA, manager or document.

In addition to the information received from the RHA questionnaires and meetings with the RHA board chairs and CEOs, the Review Committee also surveyed RHA managers and facility managers. (For the management survey questionnaire see Appendix 9.) Over 350 RHA managers and facility managers completed a 20 question survey and included extensive written comments for almost all of the questions which provided the Review Committee with very comprehensive data.

Percent of RHA budgets allocated to administrative costs

All RHAs have taken actions to reduce administrative costs, including the elimination of managerial positions (including facility manager positions) and levels of management, regionalization of administrative processes such as payroll and accounting and improved information systems for cost control. Although the Review Committee did not attempt to document and verify all of the cost-savings reported by the RHAs, the Review Committee is confident that there is a constant focus on cost savings and evidence of reduced costs.

The Review Committee was mandated to look at the administrative structures and costs of the RHAs in terms of appropriateness, transparency, value-for-money and comparability with similar jurisdictions. CIHI provides comparative reports on administration as a percentage of total operating costs for all Canadian RHAs. The 2005 CIHI provincial administrative costs data shows Prince Edward Island at 7.3% of total operating costs, Ontario 6.3%, Newfoundland 5.8%, Nova Scotia 5.6%, Manitoba 5.6%, New Brunswick 4.7%, B.C. 4.5% and Alberta and Saskatchewan 4.1%. There is no CIHI data available on this measure for Quebec. On this measure, Manitoba is in the "middle of the pack."

The data that determines the administrative cost indicator comes from the coding of expenditures by each RHA according to the CIHI Management Information Systems (MIS) Guidelines. These guidelines not only include such items as administration, executive offices, board of trustees, finance and public relations, but also include service-related items such as infection control, claims management, risk identification and quality assurance. In addition, the CIHI administrative costs include labour relations, human resources, recruitment and retention, and even mail service. In other words, it has a wide scope. Nor is it limited to corporate-office expenses; instead the administrative cost category includes costs in hospitals, non-proprietary PCHs and community health agencies.

The Review Committee has discussed the differences in the percentage of operating expenditures spent on administration with representatives of the RHAs, with CIHI and with external consultants, including the Hay Group and others that have done analysis of regional spending patterns in jurisdictions throughout Canada.

Undue attention is being paid to administrative costs as an indicator of how well the regional health system is working in Manitoba. The Review Committee says this for the following reasons:

- The CIHI list of functions included in administrative costs includes a wide range of activities. It is not, as some appear to believe, limited to the cost of the executives located in the corporate offices.

- There is not sufficient data available for an accurate determination of whether the percentage spent on administration has increased or decreased due to regionalization. Also, there are many more patient care-related services offered today than prior to regionalization related to matters such as infection control and quality management so even if data were available, it would not be comparable.

- The Review Committee has concerns about the comparability of this particular indicator across regions throughout Canada. CIHI does not conduct

comprehensive audits of the appropriate coding of expenditures to MIS accounts for measuring administrative costs. Public scrutiny is causing regions across Canada to make this percentage appear to be as small as possible. The Review Committee heard anecdotal information that suggests that some jurisdictions throughout Canada record their administrative costs in a manner that makes them appear lower on this indicator. The Review Committee does not have complete confidence in the differences currently reported between Manitoba and other provinces. It is necessary that the coding of the cost data for this indicator be audited by CIHI nationally to enable meaningful comparisons.

Therefore, comparability of administrative costs between provincial jurisdictions is problematic. There are no accepted benchmarks and weaknesses exist in the standardization of methods of accounting for administrative costs. Nevertheless, considering all of the information available to the Review Committee—quantitative and non-quantitative—the Review Committee's conclusion is that administrative costs within the RHAs are, on balance, at a reasonable level compared to RHAs in other provinces.

As noted above, public attention to administrative costs has caused an overemphasis on the importance of this factor, possibly to the detriment of appropriate attention being given to other aspects of the effectiveness and efficiency of the health system in Manitoba. However, the lack of verifiable measures contributes to public mistrust. In the absence of reliable and valid information across the provinces, the media and the public create their own assessment methodologies to fill the vacuum. While it is well and good for the Canadian health-care system to disparage these methodologies as unscientific, the ability to eliminate them is within its control. Manitoba could play an important role in achieving this goal in collaboration with CIHI.

Recommendation

9.1 Manitoba Health and Healthy Living should request that the Canadian Institute for Health Information audit Management Information System accounts to enable comparable benchmarking throughout Canada of the percentage of expenditures spent on administrative costs.

The impact of the focus on administrative costs on managerial authority and accountability

The focus on reduction of the RHA administrative costs appears to drive many decisions, possibly to the detriment of overall system effectiveness. The qualitative data received from RHA and facility managers indicates that the elimination of managers and levels of management has placed an increased burden on the remaining managers, with many experiencing burnout and a feeling of helplessness. Although

an extreme example, in some RHAs individual front-line managers are responsible for conducting up to 200 performance appraisals. More typically, managers are responsible for 40 to 60 performance appraisals. In such situations, accountability systems are impossible to implement effectively. It would be easy—but pointless—to recommend that all RHA employees receive annual performance appraisals. This is not possible in many RHAs. The manager's human resource management functions—performance assessment, goal-setting, personal development planning, coaching, personal capability assessment and talent pool management—cannot be carried out effectively in the present environment. Accordingly, individual accountability and individual support is often jeopardized.

The situation also creates a gap in managerial leadership at both the managerial and front-line level. Managers, who are already stretched too thin, must focus primarily on crisis management ("we are always one resignation away from a crisis"). As a result, they cannot provide effective leadership. Managers expressed concern over their inability, given time constraints, to provide leadership and noted that many employees do not aspire to achieve managerial positions. The conclusion of the Committee is that, although a focus on cost savings in the RHAs is appropriate and is part of the accountability process, the increasingly higher profile of the perceived issues of "administrative overhead" and "bloated bureaucracies" has resulted in a system in which effective managerial leadership has been seriously jeopardized.

Managing change and innovation

Difficulty in recruitment and retention of qualified staff is an on-going issue in all RHAs. These and other challenges (for example, the political sensitivity of health services) have fostered a management and organizational culture in the RHAs that is focused on solving short-term problems, often at the expense of exploring long-term strategies that could prevent problems from occurring. There were several questions in the managers' survey regarding change and innovation. The overall pattern of the answers and written comments indicated that most managers defined "innovation" and "change" in the context of coping with short-term crises. With some exceptions, the RHAs are either unwilling or unable able to embark on innovative and potentially long-term strategies that could both reduce costs and make the system more effective. In the quality management literature, this is referred to as the difference between "doing things right" and "doing the right things." An example of a best practice in this area is the WRHA's use of lean principles, theory of constraints, Six Sigma and process design.[7] These have been used to implement efficiencies in patient flow and establish a pharmaceutical management program in personal care homes that has resulted in safer medication distribution systems, reduced drug costs,

7 These are proven strategies for effective process re-engineering.

enhanced education, improved pharmacy collaboration and increased accountability of services. Greater effort needs to be put into these types of process improvement approaches in all regions

Notwithstanding the fact that the funds for major innovative, experimental process improvement projects would likely have to be found from budget surpluses, the rewards for embarking on innovative process solutions are few and the potential negative outcomes are many. These programs require investment of human and financial resources that are often scarce, particularly in smaller regions. Regions risk being accused of diverting resources away from front-line care, even though the objective is greater efficiency and effectiveness of resources. Change strategies such as Six Sigma, lean principles, process improvement and requisite organization have considerable potential to improve the delivery of health services in the RHAs. By utilizing the existing human resource base in a more effective manner, these processes would reduce the pressure on the system for more resources. An example of directing resources towards process improvement is the Manitoba Patient Access Network (MPAN) fund. Although limited to innovative changes to improve access, it is a good example of targeted funding for process improvement programs in the RHAs.

Structural design

Examination and discussion of the organizational structures of the RHAs would suggest that the structural alignments and functional divisions are generally appropriate for the existing accountability systems; that is, a relatively strong focus on finance, budgeting and costs. This reinforces the point, made earlier, that accountability systems between the RHAs and Manitoba Health and Healthy Living are more closely related to financial issues rather than health outcomes.

As would be expected, functional divisions vary from region to region, depending upon the specific health needs of the region. However, organization structure charts, by themselves, provide limited information about how the system functions. Critical factors, such as the managerial authority, responsibility and accountability of roles, cannot be determined from a chart. Nor does a chart provide evidence as to how effectively the authority, responsibility and accountability are being implemented. The data indicate that there are opportunities for improvement in the fundamental management processes of role design and clarification of responsibilities.

The Review Committee's analysis also indicates that decision-making is often seen as slow, with lengthy approval processes required (except in crisis situations). Lengthy approval processes within the RHAs are, of course, a predictable outcome given the comments in Section 6 (Accountability) about the need for more devolution of authority to the RHAs. Narrow limits in authority result in slow decision processes. The management literature confirms that one of the most significant characteristics of effective organizations is their ability to develop fast response capability to adapt

to changes in their environment. The managerial processes required to develop fast-response capability in organizations are also consistent with enhancing healthy work places, employee satisfaction, employee development and effective achievement of organizational goals.

Recommendations

9.2 Manitoba Health and Healthy Living should provide incentive funding for regions to undertake leadership roles in innovative process improvement interventions that can be shared with other Regional Health Authorities.

9.3 Manitoba Health and Healthy Living should support the Regional Health Authorities to develop and implement systems to ensure effective human resource management practices and accountability processes for front-line managers and front-line staff.

10. Planning

Regionalization has provided the opportunity for focused, long-term planning for the provision of health services based on the assessment of regional health needs and local input. The Review Committee's discussion of planning looks at the Community Health Assessments and community involvement strategies that provide the bedrock for such planning, and the state of strategic planning, regional service planning and target setting in the RHAs.

Community Health Assessments

Every five years, each RHA undertakes a Community Health Assessment (CHA), making use of Manitoba Health and Healthy Living's *Community Health Needs Assessment Guidelines*. These assessments help the RHAs obtain an overall understanding of the health status of the region's population and the determinants of health. One of the methods used for obtaining information for the CHA is through community participation. Information-gathering sessions in the communities allow for community involvement and are essential in the compiling of a list of specific health issues and needs. On the basis of the CHA, the RHA develops a five-year strategic plan and annual health plans to guide the implementation of RHA strategies.

The Manitoba Centre for Health Policy (MCHP) is a valuable source of information that the RHAs use in developing their CHA. MCHP provides evidence-informed reports that compare outcomes and practices within and between regions. Other data sources for the CHAs are health-information management regional profiles, census data, national survey data and community consultations.

The Need To Know Team of the Manitoba Centre for Health Policy has representation from all RHAs and Manitoba Health and Healthy Living. The team members collaborate on research and produce data that is used in evidence-based decision-making and planning. Collaborative research has produced a provincial *Indicators Atlas* (2003) to assist the RHAs in developing five-year strategic plans. The CHA provides each RHA with a unique opportunity to identify and prioritize health needs for the communities within that region, as well as assisting in developing their Health Plans and Strategic Priorities.

During the planning process, facilitation of French language services is considered in a number of regions. The work of Central RHA in facilitating and integrating the delivery of French language services within the region's existing organizational framework was honoured with the 2007 Ronald Duhamel Award and constitutes a best practice.

The RHAs view the Community Health Assessment process as a valuable means to:

- Help set priorities
- Ensure decisions are based on evidence
- Assist in assessing outcomes
- Involve community members, stakeholders and other partners in decision-making
- Provide information to assist with funding allocation
- Assist in developing policy and programs
- Identify opportunities for disease prevention and health promotion

While not exhaustive, this list gives an indication of the positive outcomes that the RHAs identified with this process.

Community involvement

The Regional Health Authority Act requires the creation of District Health Advisory Councils (DHAC) unless the Minister of Health approves otherwise (this approval has been granted on several occasions). In some regions, these councils are referred to as Community Health Advisory Councils (CHAC). The Councils, which are directly responsible to the RHA boards, are intended to allow for public consultation and input into decisions about health, community health needs and priorities of health services in the region. The Review Committee has concluded that the success of the DHACs and CHACs varies widely from region to region.

Some RHAs have also developed Provider Health Councils, which are composed of employees of the RHA. Although the employees have direct contact with the public, the mandate of these councils is to provide a link between employees and the board of directors of the RHA. For this reason, they should not be viewed as substitute instruments of community involvement.

The Review Committee surveyed the DHAC/CHAC members, seeking their input as to the effectiveness of the committees. (For a sample of the survey instrument, see Appendix 11.) The responses identified a level of dissatisfaction in some regions. Some respondents felt that, while the RHA shared quality information with the Advisory Councils, council members were not able to make meaningful input, particularly when it came to resolving problems. There was also difficulty in recruiting individuals to become members of the council due, in part, to the aging population, the difficulties associated with travelling long distances to attend meetings and the cost associated with travelling. There is benefit to having the appropriate representation on the advisory committees. In some RHAs, membership could include members from the town council, members from the municipality, health-care providers, businesspersons, representatives from the seniors groups, Aboriginal representatives and representatives from other significant organizations within the community or district.

Although the provincial government mandated the DHACs in the *Act,* there has been little, if any, provincial monitoring of the effectiveness of these councils or any other form of community input. Therefore, the regions have not been held accountable for ensuring that the community involvement process is effective, nor do they have to formally report on their methods and results. Dissatisfaction in some regions has been allowed to continue with no corrective action. This is a critical weakness in accountability since community empowerment is a key ingredient in maximizing the potential of regionalization. It is worth noting that some RHAs use participation and input from other community stakeholders in conjunction with the DHAC/CHAC. Examples of this include meetings with agencies, organizations, town councils, municipalities and other stakeholder groups on a regular or as-needed basis. Public surveys and public forums are also used to share information and gather community input.

The Winnipeg Regional Health Authority has achieved considerable success in the use of its DHAC/CHACs by providing them with a dedicated staff member to facilitate the discussion on specific health-related issues. Topics for discussion at Council meetings are related to the RHA's Health Plan/Strategic Plan, which is identified by the board as a priority for community input. The DHAC/CHAC develops recommendations that are forwarded to the board. This method provides a focused approach on specific issues that are important to the region and/or the community.

It should also be noted that with the permission of the Minister of Health, some RHAs have discontinued the use of DHAC/CHAC in instances where the RHA could substantiate how they were going to have community input.

The benefits of community involvement are numerous and the investment of time and money into this process is essential. An excellent example of community involvement is the process used to develop the Community Health Assessments every five years. Creating a trusting relationship and engaging and empowering the community takes time, work and patience. There is a host of literature available to support community engagement and empowerment.[8] The literature suggests that effective community empowerment and consultation should incorporate the following principles:

- Identification of issues of common concern in order to strive for a common goal
- Identification of relevant organizations and community leaders to work in a collaborative fashion
- Providing community members with information and knowledge so that informed evidence-based decisions are made
- A democratic process

The Review Committee notes that some regions have developed approaches to community involvement that are innovative and reflect unique characteristics of the region. For example, Central Region has created a Spiritual Care Advisory Committee because the region sees spiritual care as an integral part of the continuum of care. Such practices create an increased feeling of ownership in the region and constitute a best practice.

The efforts and successes of the RHAs to involve communities are commendable, particularly in light of the challenges they face. However, the Review Committee believes there is room for improvement.

Recommendations

10.1 Manitoba Health and Healthy Living should require Regional Health Authorities to be accountable for and report on the development of effective methods of obtaining community input through the District

8 For example see: Vancouver Costal Health Authority Community Engagement, www.vch.ca; Capacity Building; Linking Community Experience to Public Policy" (Atlantic Region) www.phac-aspc.gc.ca; Public Health Leadership: Putting Principles into Practice by Louis Rowit (Jones and Bartlett Publishers 2003); and Methods in Community-Based Participatory Research for Health by Barbara A. Israel (Jossey-Bass July 2005).

Health Advisory Councils, Community Health Advisory Councils or other community engagement mechanisms chosen by the region.

10.2 Regional Health Authorities should implement methods to engage and empower their communities and districts based on the following principles: (a) identifying issues of common concern to strive for a common goal, (b) identify relevant organizations and community leaders to work in a collaborative fashion, (c) provide community members with information and knowledge so that informed evidence-based decisions are made and (d) have a democratic process.

Strategic planning

Each Regional Health Authority has established a five-year Strategic Plan, based on the Community Health Assessment finding for the region. This plan enables the RHA boards to set priorities and specific goals that, in turn, include a regular monitoring process. Some of the common themes that emerged from a review of each RHA strategic plans for 2005/06 to 2010/11 are:

- Establishment of primary care centres
- Aboriginal strategies
- Health promotion and prevention
- Human resource strategies
- Planning for capital needs
- Chronic disease management
- Mental-health needs
- Promoting a healthy staff
- Information technology
- Education of staff
- Disaster planning
- Patient safety

The RHAs monitor each of the priorities to track whether initiatives are being undertaken to move it forward. This allows the RHAs to evaluate progress in relation to the uniqueness of their specific region and, if necessary, change the plan.

Regional service planning

Throughout the RHAs there is a strong desire to plan health services that are needs-based, evidence-based, cost-effective, and efficient to provide safe quality care to the patients. The RHAs fully understand that the removal or addition of health services to a community has a pronounced effect on the economy of the community and its viability and, therefore, has the potential to become a political issue. The RHAs also believe that the maintenance of service provider skills and competency are of utmost importance for patient safety and positive patient outcomes. Through a consultative process with the community, the RHAs need the ability to make decisions on what services should be provided in each community that best suit their unique regional needs.

Each RHA should develop and publish a regional service plan that describes the mix of services and service volumes that will be offered in each local community. These services potentially include primary care, acute care, home care, personal care homes, supportive housing, mental-health services and various other kinds of care across the continuum. Benchmarking against other jurisdictions can provide guidance in determining an appropriate mix of services. For example, Manitoba has a very large number of personal care home beds compared to other jurisdictions in Canada. This could mean that Manitoba has fewer community services available such as assisted living arrangements. Regional service plans would provide guidance for the construction or renovation of facilities including hospitals, PCHs, community health centres and ambulance stations. They will also provide the basis for recruitment strategies for physicians, nurses and other health-care staff in numbers appropriate to the services to be offered in each community. In developing these plans it is essential to engage local communities, both seeking their input and helping them understand how the placement of resources will provide them with more effective health services.

The Review Committee concluded that there is a reluctance to publish regional service plans for the Manitoba RHAs. The Manitoba government appears to be concerned about how communities will react if they are told that a local hospital may close. Municipal elected officials told us that they would prefer for there to be published regional service plans that provide them with information on the future of local health institutions and services.

Regional service plans must be developed through good community development processes. Making decisions on what is the best way to provide health services throughout the region should be the responsibility of the RHAs and they should be held accountable to Manitoba Health and Healthy Living and to their communities.

However, even with the best processes, there still may be some people that are not in agreement with the final decisions. Nevertheless, these decisions must be made to ensure an effective and efficient health services system.

Recommendations

10.3 Manitoba Health and Healthy Living should establish guidelines for planning health services provincially and regionally. In doing so, it should provide a systemic, evidence-based methodology that would include input from the communities, districts and region for determining what services should be provided in each community.

10.4 All Regional Health Authorities, in collaboration with their communities and using benchmarks from other jurisdictions, should develop and publish regional service plans that specify the appropriate mix, capacity and location of services in their region.

Target setting

In meetings with the CEOs and chairs of the RHAs, the Review Committee questioned them about RHA outcomes and the major initiatives their RHA has undertaken in recent years to increase service cost effectiveness. The Review Committee also undertook inter-provincial comparisons at the RHA level, using a peer grouping methodology developed by Statistics Canada based on 24 variables including factors such as basic demographics, living conditions and working conditions. In meetings with the RHAs, the Review Committee discussed how their performance compares to the performance of their peer regions from across Canada. The Review Committee also discussed with the RHA CEOs and board chairs the ways in which they are addressing areas where RHA performance is not as good as peer performance and the trends in their performance over time.

There were three reasons to question individual RHAs about their performance in comparison with that of their peers throughout Canada. The first was to better understand how the board and management of each RHA identified opportunities to improve their service delivery system. A second reason was to determine the information they had or were using. The third reason was to understand the extent to which the RHAs are setting targets for improvement within the RHA and between the RHA and Manitoba Health and Healthy Living. The Review Committee's conclusion on this latter point is that most RHAs do not set performance targets for measures such as health status, service delivery and outcomes. Most of their performance measures relate to whether activities are being completed. A few RHAs have well-developed scorecards incorporating quantifiable performance targets but most do not. The Nor-Man and South Eastman RHAs, which have scorecards that

compare actual performance indicator results to targets and show performance trends, provide good examples of good internal reporting systems and best practices in this area. The accountability relationship between Manitoba Health and Healthy Living and all of the RHAs does not include quantifiable performance targets except for the components of the wait-time strategy. Greater use of performance targets by Manitoba Health and Healthy Living would improve accountability and ensure the RHAs are able to maintain and pursue provincial priorities as well as local priorities.

A Statistics Canada peer grouping methodology provides a mechanism to establish benchmarks from other regions in Canada for performance target setting in each RHA. The purpose of setting these targets and measuring progress against them would be to increase accountability for performance internally within the RHA as well as to increase accountability with Manitoba Health and Healthy Living and with the communities that the RHA serves.

Most of the RHAs indicated to the Review Committee that they do not have easy access to a comparative performance indicator database that they could use for setting targets. This is something that Manitoba Health and Healthy Living could supply. At the moment the RHAs receive many reports compiled by Manitoba Health and Healthy Living on activity levels but receive far less on comparative performance.

Recommendation

10.5 Manitoba Health and Healthy Living should establish a provincial comparative performance indicator database to enable performance indicator target setting within the Regional Health Authorities and negotiated quantitative target setting between Manitoba Health and Healthy Living and the Regional Health Authorities for improving health status, service delivery and outcomes through accountability on these measures and targets.

11. Funding and Finance

Operating funding for RHAs

The Review Committee's review of the funding model in the RHA system indicates that considerable attention is being paid to balancing operating budgets. Nevertheless, the opportunity exists to make operating funding processes more transparent and timely.

Each year, RHAs are required to submit a balanced operating budget to Manitoba Health and Healthy Living based upon the revenues the RHAs will receive. The RHAs comply with this requirement and submit any additional requests for funding for new initiatives as a component of their annual Health Plan submission. RHA CEOs and board chairs told the Review Committee that Manitoba Health and Healthy Living has provided very limited feedback regarding these additional requests over the past few years.

While many of the RHAs have had frequent operating deficits over the seven years of results that were reviewed, the size of most of these deficits has been small. Recurring deficits are, however, eating into the cash reserves of many of the RHAs, forcing them to manage through lines of credit with the banks and, in some cases, cash advances from Manitoba Health and Healthy Living.

A major concern regarding the RHA funding process is its lack of transparency. The Review Committee was told that, at the time of regionalization, the RHA global budgets were determined by the sum of the budgets of the pre-existing organizations.

Over the past ten years, each of the RHAs has received operating budget increases to their global budgets from Manitoba Health and Healthy Living without a specific and transparent methodology to demonstrate why one RHA received a different percentage increase than another. This lack of transparency has led RHAs to have serious questions about the fairness of the process. This creates the risk that RHAs could believe that larger increases are given to RHAs that overspend their budgets. Effective accountability of the RHAs to Manitoba Health and Healthy Living requires the implementation of a transparent funding model. Transparency does not necessarily mean that a totally computational funding model is required; rather, it means that the *factors* used in the budget allocation decisions should be known to the RHAs.

Besides the global budget increases provided to the RHAs, Manitoba Health and Healthy Living also provides funding specific to implementation of provincial priorities. An example of this is the funding provided to the RHAs through the provincial government's Wait-Time Reduction Fund. RHAs receive funds to increase service volumes through this additional funding.

At the request of Manitoba Health and Healthy Living, the Manitoba Centre for Health Policy (MCHP) has been working with the RHAs to develop a population-based funding model. Several provinces in Canada are developing or using some form of a population-based funding model and this appears to the Committee to be a reasonable approach to take. This potential new model is still in the discussion phase and requires more dialogue and a consensus among the MCHP, Manitoba Health and Healthy Living and the RHAs. While most RHAs are in agreement with the general direction being taken, they expressed concerns about the comprehensiveness of the current model.

The Review Committee believes that the new funding model should include both a population-based component as well as a component for service volumes and performance. The funding model should enable Manitoba Health and Healthy Living to continue to be able to provide financial incentives for increased volumes or improved performance for specific services on a provincial and RHA basis to enable the implementation of provincial priorities.

Recommendation

11.1 Manitoba Health and Healthy Living, in collaboration with the Regional Health Authorities, should implement a transparent methodology for funding Regional Health Authorities that allocates funds based on differences in regional population needs as well as providing explicit financial incentives to increase service volumes and performance where appropriate.

Operating funding for facilities

While hospitals and personal care homes throughout the province are funded by the RHAs, there is no standardized provincial methodology for determining these funding levels. Many non-devolved PCHs and hospitals expressed concerns and, in some cases mistrust, as to how RHAs set funding levels in relation to the volume and needs of the PCH residents and patients.

In some RHAs, the PCH funding levels are based on historical funding levels, with percentage increases equivalent to the funding increases received by the RHA. One RHA has implemented a weighted-resident-day funding methodology that is based on the current level-of-care methodology that the Manitoba government uses for resident classification. While the WRHA has been funding those PCHs that it is responsible for at the median rate per resident-day (while protecting those homes that were initially above the median rate from funding reductions), it is now implementing a PCH resident classification system called Minimum Data Set/Resource Utilization Groupings (MDS/RUGS). The WRHA will use the MDS/RUGS assessment of the mix of resident needs, which is used in some other Canadian jurisdictions, to help make equitable funding allocations to PCHs.

As a matter of policy, the WRHA not only funds all PCHs in its region but also funds all the private-for-profit PCHs in other RHAs. Because it funds all facilities (both non-profit and for-profit) at the same rate, tensions arise in those regions where the WRHA funds for-profit PCHs at one rate and the local RHA funds the not-for profit PCHs at a different rate. A standardized methodology for funding all Manitoba PCHs is needed to resolve these inconsistencies.

There is no clear funding methodology for hospitals. It appears that in most cases historical funding levels are the primary determinants of current funding levels. However, there has been some volume-based funding provided to hospitals to encourage increased capacity as part of the provincial wait-time reduction strategy.

Some non-devolved hospitals told the Review Committee that they would prefer to be funded on the basis of a methodology that pays for the volume of patients served at a negotiated rate. They believe that this formula would provide the necessary funding to serve the volume of patients that use their services. The Review Committee is supportive of a funding methodology for hospitals that pays them for the volume and mix of services that they provide. However, if hospitals do not achieve the volumes, they should be required to return the funding associated with the shortfall to the RHA.

Recommendation

11.2 Manitoba Health and Healthy Living, in collaboration with the Regional Health Authorities, should establish funding methodologies for Regional Health Authorities to fund personal care homes and hospitals based on

the volume and level of care requirements of the residents/patients that they serve.

Funding timing

Currently, Manitoba Health and Healthy Living cannot send out operating funding allocation letters to RHAs until after the provincial budget has been approved by the legislature. This means that RHAs do not receive these letters until after the start of their budget year, limiting their ability to make timely allocations to their own cost-centre managers and to the non-devolved organizations that they fund. In recent years, the length of the delay has somewhat shortened, but RHAs have still not been receiving their allocations before the beginning of their budget year. These delays complicate budgeting for all concerned and reduce accountability for effective operating budget management. Manitoba Health and Healthy Living has attempted to improve this situation by giving the RHAs budget planning targets well in advance of the fiscal year. However, the actual increase in funding received by an RHA may differ significantly from the target. Given that the funding methodologies are unclear, it is difficult for an RHA, cost-centre managers and their non-devolved organizations to predict their actual funding level in advance.

Historically, late funding announcements have been a problem for effective budget management in health services throughout Canada. In the past couple of years, Ontario has implemented a new system of funding announcements for its hospitals. The new multi-year funding system provides individual allocations to hospitals nine months in advance of their budget year and targets for funding for all hospitals for the second and third years. This enables hospitals to plan their initiatives more effectively into the future and increases their accountability for achieving results while balancing their budgets.

Recommendation

11.3 The Government of Manitoba should modify funding processes to enable specific operating budget allocations to Regional Health Authorities and from Regional Health Authorities to their cost-centre managers and non-devolved organizations well in advance of the beginning of their budget year as well as providing targets for the second and third years.

Efficiency benchmarking

Manitoba Health and Healthy Living allows RHAs to reallocate operating funds across sectors and within operating units so long as patient-service levels are not impacted. If patient-service levels for a particular location are to be reduced, the RHA must first seek approval from Manitoba Health and Healthy Living. Most RHAs

believe that, even if they do not reduce service levels, their constrained funding levels mean that they have limited ability to move significant amounts of funding from one cost centre to another or to fund new initiatives.

The Committee's review indicates that there is little use throughout the RHA system of clinical and operational efficiency indicators and benchmarking against other jurisdictions in developing operating budgets. Many RHAs indicated that cost and service delivery performance data is not readily available from Manitoba Health and Healthy Living for other RHAs or from comparable peer regions across Canada. The WRHA participates in a national benchmarking service that enables it to assess the clinical and operational efficiency of the Health Sciences Centre and the St. Boniface General Hospital and, on some indicators, of the region overall. The Hay Group management consultants and the Canadian Institute for Health Information (CIHI) provide this benchmarking service. No other Manitoba RHA has participated in the Hay/CIHI benchmarking service to date. At Manitoba Health and Healthy Living's request, some of the smaller regions that have had difficulty balancing their budgets have had efficiency reviews conducted by an external consulting company.

All RHAs have implemented numerous initiatives to improve efficiency. An example of a best practice to improve efficiency in the Burntwood RHA is the Advanced Access model of patient scheduling. It balances and streamlines patient appointments with demand, allowing quicker access to services. The improvement of service delivery in Burntwood since the implementation of this model has allowed it to accommodate from 500 to 1,000 more visits per month.

As noted previously, Statistics Canada has recently established a peer grouping methodology for all health regions across Canada. This methodology will enable Manitoba RHAs to compare their performance to the current performance of similar regions and develop benchmarks to strive for in improving their performance. For example, the peers for the North Eastman RHA include health regions such as Palliser in Alberta and Interior Health in British Columbia.

RHAs would benefit greatly from benchmarking their efficiency in comparison to other Canadian regions as part of their budget development process. Any potential savings identified could be used to reallocate resources to new or ongoing services. The identified savings could also help the RHAs balance their budgets within the funds provided by Manitoba Health and Healthy Living. The benchmarking should be done to the best quartile of peer RHAs from across Canada. This means that the Manitoba RHAs should strive to be more efficient than 75% of their peer regions. This may not be possible or advisable in all cases, but it will provide the maximum opportunity for identifying potential efficiencies for reallocation of resources.

Recommendation

11.4 All Regional Health Authorities and their non-devolved organizations should utilize national peer group best quartile benchmarks for clinical and operational efficiency to improve the sophistication of their budgeting processes to enable efficient operations and internal reallocation of resources.

Capital expenditures

According to CIHI, total health services capital expenditures over the past seven years in Manitoba have been similar to the average for all Canadian provinces on a per capita basis. In Manitoba, RHA capital expenditures are categorized for planning purposes into expenditures on basic equipment (such as beds and lifts), specialized equipment (such as MRI machines), safety and security projects (such as a boiler replacement), major construction projects/renovations of facilities and information and communication technology (ICT) projects.

The Review Committee was not able to obtain data on the average age of facilities in Manitoba compared to those in other provinces. There is, however, data on the age of equipment as well as the magnitude of expenditures on ICT. In 2004/2005, the average age of equipment used in the RHA system in Manitoba was 11.7 years. Equipment in most RHAs was less than 10 years old on average but for the WRHA it was almost 18 years old. The comparative figures for Ontario are 9.0 years, Alberta 3.3 years, British Columbia 9.6 years and Saskatchewan 15.3 years. For ICT, CIHI data shows that Manitoba has been spending much less than the average of other provinces. From 2001 to 2005 Manitoba spent at the rate of about 1% of its total RHA budgets on ICT, whereas the average in other provinces was 2%.

All RHAs have processes for developing prioritized lists of needs for capital equipment and major construction/renovation projects with input from managers in their devolved and non-devolved organizational units. These lists are approved by the RHA boards and submitted to Manitoba Health and Healthy Living. ICT projects are submitted for approval to the eHealth Provincial Program Board.

The amount of funding available for health-services capital is constrained by a ceiling placed on principal and interest payments by the Manitoba government to maintain its ratio of debt to gross domestic product at a reasonable level to protect its credit rating. This includes principal and interest on borrowings for expenditures on specialized equipment, safety and security projects, major construction projects/renovations of facilities and ICT. The setting of a capital financing ceiling has encouraged careful planning and prioritizing of capital expenditures throughout the RHA system. However, the ceiling has created a challenge for RHAs as they attempt to meet all the important emerging needs for capital. Moreover, the ceiling placed on

capital spending has only been increased by a total of 3% over the last seven years, a period of significant construction inflation plus increasing pressures to replace old equipment and develop electronic health records.

With all this pressure on capital, Manitoba Health and Healthy Living needs to look at alternative financing options. These options could include public/private partnerships for the construction of facilities, the leasing of equipment and the use of external service providers for ICT services and diagnostics.

Recommendation

11.5 The Government of Manitoba should pursue a variety of alternative financing options, such as public/private partnerships for the construction of facilities, the leasing of equipment and the use of external service providers for information and communication technology services and diagnostics, that would enable the greater use of capital by the Regional Health Authorities for safe, efficient and effective care.

12. Information and Communications Technologies

Investment in information and communication technologies (ICT) to improve the health system became a national priority with the creation of Canada Health Infoway in 2001. Infoway is an independent, not-for-profit organization whose board members are Canada's 14 federal, provincial and territorial Deputy Ministers of Health. It invests in a common, pan-Canadian framework of electronic health-record systems. The federal government has provided $1.6 billion in funding for Infoway, which generally funds about 50% of the total project cost with the provincial government funding the remainder. Manitoba currently receives funding from Infoway for nine projects.

In Section 11 (Funding and Finance) it was noted that the Manitoba Government has placed a ceiling on the funding available for health-services capital in Manitoba. The ceiling includes principal and interest on borrowings for expenditures on specialized equipment, safety and security projects, major construction projects/ renovations of facilities and ICT. The prioritizing of ICT within this capital financing ceiling in relation to other capital needs has resulted in ICT in Manitoba receiving

quite limited funding compared to what ICT receives in the rest of Canada. During the period 2000/01 to 2004/05, Manitoba RHAs, in total, spent at a rate of about 1% of their operating budgets on ICT. Ontario and Alberta spent approximately 2.5% of their operating budgets on ICT during this period and Nova Scotia, New Brunswick and British Columbia spent over 2% in the later years of this period. The difference between 1% and 2.5% of the Manitoba RHA operating budgets in current dollars is approximately $40 million each year. As a result of minimal spending on ICT, Manitoba RHAs, overall, have very limited computerization and a large backlog of needs for investment in ICT. Alberta has the most advanced ICT capabilities of any province in Canada. In 2008, approximately 50% of primary care physicians in Alberta will have electronic access to laboratory, radiology and drug information on their patients, up from approximately 33% in 2007. This compares to less than 10% in Manitoba. Alberta has been so successful because the Premier of Alberta publicly announced that ICT was a provincial priority many years ago, there has been a continuing high level of investment in ICT in that province over a period of about 10 years and there has been effective project management.

Recommendation

12.1 The Government of Manitoba should make a public commitment to health-service related information and communication technologies, commit itself to the appropriate level of funding and ensure that its information and communication technologies initiative has effective project management.

Electronic health records

Electronic health records are an essential part of modern health-services delivery. These records provide for the secure and privacy-protected sharing of electronic information on the care of patients among all health-care workers involved in their care. These records can link doctors and nurses and other community care providers with each other and with laboratories, pharmacies and hospitals. From the patient's perspective, this ensures that accurate information moves with them, no matter who they are seeing, eliminates undue risk and gives them more timely access to care. Electronic health records are necessary to achieve the benefits of regionalization. Integration of care across the continuum is a key goal of regionalization and cannot be effectively accomplished without the implementation of electronic health records.

The Brandon RHA has invested in electronic health records over the years and its work should be considered an example of a best practice. The Brandon Hospital system allows staff to register patients in all acute care settings, place doctors' orders, view test results and chart information electronically. Moreover, two major clinics

in the Brandon RHA have their computer systems linked to the hospital system, allowing doctors to receive information on patient test results electronically.

Historically, Manitoba Health and Healthy Living has assessed RHA requests for funding of ICT projects on a case-by-case basis. During the 2007/2008 planning cycle, Manitoba Health and Healthy Living established a centralized process for planning and funding ICT projects following a five-year plan that is called the eHealth ICT Roadmap. When the initiatives that would need to be undertaken over the five-year period and the resources necessary to carry them out were defined, it was concluded that the resource requirements of the defined initiatives surpass the availability of resources both in terms of money and skilled people to do the work. Manitoba's eHealth strategy will require sufficient funding and very effective project management to be successful. Manitoba will be competing with all of the other provinces for scarce ITC professionals at a time when all of the other provinces have made electronic health records a priority. As a result, attracting skilled staff to manage and carry out these projects will be a major challenge. Nevertheless, Manitoba Health and Healthy Living deserves credit for establishing an eHealth ICT Roadmap and a governance structure that prioritizes all clinical and non-clinical ICT needs in the province.

The Review Committee's experience suggests that annual external risk management reviews of the implementation of ICT strategies can reduce the risk of implementation failure. These reviews can be used to provide an independent perspective on how well the ICT strategies are being carried out and what can be done to increase their likelihood of success. Given that Manitoba has such a large backlog of ICT work to be accomplished in such a short period of time, an annual external risk management analysis would be of considerable benefit in the Manitoba situation.

Recommendation

12.2 Manitoba Health and Healthy Living should contract with an external consulting group to conduct an annual risk review on the progress being made in the implementation of the Manitoba eHealth strategy.

Clinical telemedicine

MBTelehealth (MBT) was formed in 2001 to provide telehealth video conferencing throughout Manitoba. MBT has expanded from 8 to approximately 60 sites across Manitoba. Sixty per cent of sessions are for clinical purposes, 20% for education, 10% for administration and 5% for other purposes. Over 250 physicians from more than 25 clinical specialties use MBTelehealth. This means the service is used by only 15% of Manitoba specialists. A recent external review by a consultant suggests that the specialists currently using telehealth in Manitoba are early adopters (people that

like to try new ways of doing their work) and that it will require specific strategies to get large numbers of other specialists to accept telehealth as an effective means of providing care. The consultant's report also notes that the current fee schedule in Manitoba for family physicians acts as a barrier to telehealth use, since family physicians are not eligible for payment for consultations with a client via telehealth unless they are assisting a specialist. Another factor limiting service expansion is the lack of reliable high-speed network access to First Nations and other remote communities.

Resources for telehealth are also limited and stretched quite thinly. The consultant's report states that, while service volumes have increased by 300%, MBT has not received any increases in funding beyond the cost of living since 2003.

Telehealth can provide major benefits to a province such as Manitoba, including reduced patient travel time and improved access to health services in the community, reduced cost of accessing care and enhanced ability to support inter-disciplinary care in remote communities. The Review Committee's discussions with the representatives of the RHAs indicate that there is great, unmet demand for the expansion of telehealth services. Some RHAs have very little telehealth service, while others, such as the Norman RHA, have made very good use of telehealth services. The Norman RHA best practice has telehealth at all three of its acute care sites and plans to expand it to community sites. Telehealth is used in the Norman RHA to link family physicians with consultants primarily for surgery, dermatology, oncology and mental health.

Recommendation

12.3 Manitoba Health and Healthy Living should take steps to accelerate the implementation of clinical telemedicine throughout Manitoba to enable efficient and effective care close to home to make regionalization function more effectively.

Shared business ICT solutions

Prior to regionalization each hospital and facility had its own ICT systems for human resources, financial accounting and supply management. Since the beginning of regionalization, all RHAs have pursued shared business ICT solutions for these functions within their own region. The least progress was made in Winnipeg, where there has been limited common implementation of these systems across sites. Recently the WRHA undertook a business process solutions project to look at ways to standardize and integrate the aging business processes and technologies for human resources, financial accounting and supply management across the region. The estimated cost of replacing systems was considered to be prohibitive and it would have to compete with all other capital expenditures under the capital ceiling for

health. As a result, a request for proposals was issued to identify a proponent willing to provide the capital for upgrading these systems.

Based on experience in other locations, such as in Toronto, the Review Committee believes that shared business ICT solutions are a sound strategy for providing transaction-based services for human resources, accounting and supply management. Given that Manitoba is a small province in terms of population, it should be possible to extend the WRHA initiative ultimately to all RHAs with a single service provider. This should generate direct savings through more efficient processing functions. In addition, this will enable the creation of both a common human resources database that can be used for more effective human resources planning and a common supply management database that can be used for more effective joint purchasing.

Recommendation

12.4 Manitoba Health and Healthy Living and the Winnipeg Regional Health Authority should ultimately include all Regional Health Authorities in establishing shared business information and communications technologies solutions to provide transaction based services for human resources, financial accounting and supply management.

13. Aboriginal Health

Based on Census data, in 2001 there were 150,040 people who identified as Aboriginal (First Nation, Metis and Inuit) residing in Manitoba (13.6% of Manitoba's total population). Within the Aboriginal population at this time, approximately 60.2% identified as First Nation, 37.9% identified as Metis and the remainder is made up of Inuit and/or individuals who provided multiple Aboriginal responses. There are 64 First Nation communities within the 11 Regional Health Authorities. The majority of Manitoba's Aboriginal people lived within either the Winnipeg RHA (52,755) or Burntwood (31,235). Over half the Aboriginal population (56%) lives in these two RHAs. Table 13.1 outlines the number of First Nations communities in each RHA and gives the percentage of Manitoba Aboriginal Population by RHA in 2001.

Increased awareness of Metis issues and constitutional discussions, along with better enumeration, has contributed to the increase in the percentage of the population identifying as Metis. It is important that Manitoba Health and Healthy Living and Regional Health Authorities continue to partner with this population, in order to recognize the values, culture and health needs of the Metis people. There is currently work underway with the Manitoba Metis Federation, Manitoba Centre for Health Policy and Manitoba Health and Healthy Living to address the health needs of the Metis population.

Inuit residents from Nunavut also access Manitoba health services, usually through either the Churchill RHA or the WRHA. It is estimated that over 15,000 Inuit residents of Nunavut potentially seek health services in Manitoba.

There are unique challenges in the delivery of health services to the Aboriginal communities. This is particularly the case for First Nation on-reserve communities, where there is jurisdictional ambiguity and lack of clarity as to the respective roles and responsibilities of the federal and provincial governments with regard to health and social services to First Nation peoples. The ongoing discussion between all parties with no resolution regarding "who pays for what" has a negative impact on First Nation people. This issue results in fragmented services, problems coordinating services, under funding, inconsistencies, service gaps and lack of integration.

Table 13.1: Regional Health Authorities with the number of associated First Nation Communities (2002) and Percentage of Manitoba Aboriginal Population by RHA in Manitoba 2001

Regional Health Authority	# of First Nation Communities	% of Manitoba Aboriginal Population
Assiniboine	7	3.7%
Brandon	0	2.6%
Central	6	6.2%
Parkland	7	6.8%
Interlake	9	9.3%
Norman	5	6.3%
Burntwood	21	20.8%
Churchill	0	0.3%
North Eastman	8	6.2%
South Eastman	1	2.6%
Winnipeg	0	35.2%

The Aboriginal population is growing at a significantly higher rate than that of the overall Canadian and Manitoba population. In general, the Aboriginal population in Manitoba continues to have a poorer health status than that of the non-Aboriginal population, thus requiring higher rates of utilization and cost for health services for most Manitoba regions.

Health status is affected by a number of different socio-economic determinants, including lifestyle, education, employment and income, housing and infrastructure, traditional language and culture. Addressing these determinants may have a positive impact on health outcomes for all Aboriginal people in Manitoba.

All Regional Health Authorities have Aboriginal health strategies, which appear to be effective to varying degrees. Although significant time, money and effort have been provided to address the issue, much more work is required.

The Aboriginal population living off-reserve accesses health services in the same manner as all other Manitobans. Providing health services in the First Nations communities is often a greater challenge due to jurisdictional issues. In some regions,

the RHA provides diabetes education in some First Nations communities, as well as chronic disease prevention initiatives. In addition, a few primary care centres have been established to service First Nation people. The RHAs have also developed strategies to improve employment opportunities and make health-care providers aware of the cultural needs of Aboriginal people. Informing Aboriginal students about health-services careers and assisting them in attending job fairs encourages Aboriginal people to further their education. Many RHAs have developed cultural awareness education sessions for staff, as well as providing interpreters who speak Aboriginal languages. The Burntwood Regional Health Authority, for example, employs Aboriginal Liaison Workers in the Thompson General Hospital (a regional hospital) and at the Burntwood Community Health Resource Centre. These workers provide support for Aboriginal clients/patients and the clinical and other staff in terms of language translation, cultural awareness and understanding, and access. The Review Committee regards this initiative as a best practice.

The Winnipeg Regional Health Authority has a unique role (given its concentration of tertiary hospitals, specialists, and specialized technology) in providing health services to Aboriginal people both within the City of Winnipeg and across all regions in the province.

The final report of *First Nations Health and Wellness in Manitoba: Overview of Gaps in Service and Issues Associated with Jurisdiction Final Report 2005*, the two reports arising out of *The Role of First Nation People With Regional Health Authorities* forums March 2004 and the report of the Commission on the Future of Health Care in Canada (the Romanow Commission), contain important recommendations relating to the health status and the delivery of health services to Aboriginal people in Canada in general, and Manitoba in particular.

The Review Committee understands that there is a long-standing and historical relationship between the Manitoba government, the federal government and the province's Aboriginal people, and that this relationship is evolving through a series of complex negotiations. While recognizing the importance of these jurisdictional issues, there must be determination from all parties to address the provision of health services for a growing Aboriginal population in a holistic and expeditious manner.

Manitoba Health and Healthy Living has made Aboriginal health a priority. It has, for example, an Aboriginal Health Branch, that, among its other responsibilities, works with the individual RHAs and the other identified parties. This Branch, as part of Manitoba Health and Healthy Living, works in partnership and acts as a liaison with other jurisdictions, political territorial organizations, tribal councils, federal and provincial departments, Regional Health Authorities and community organizations. The Review Committee noted that there are several initiatives currently in progress to improve health outcomes for Aboriginal people. These initiatives include: (1) the Aboriginal Health Transition Fund (AHTF) (which funds

specific projects), (2) Norway House Dialysis Memorandum of Understanding and (3) the Intergovernmental Committee on First Nations Health (ICFNH) (which is working on papers in the areas of service gaps, fiscal analysis, primary care and human resources development).

Recommendations

13.1 Manitoba Government, Manitoba Health and Healthy Living, Regional Health Authorities, First Nation representatives and the federal government should resolve jurisdictional and funding issues in an expeditious manner.

13.2 The Regional Health Authorities, with assistance from Manitoba Health and Healthy Living, should address the health and health services needs of Aboriginal people by setting specific targets for improvement in health and health services outcomes.

14. Specific Service Issues

The Review Committee did not conduct an in-depth review of all facets of service delivery. It did, however, identify several issues in service delivery that should be given priority to enhance the effectiveness of the RHAs. These include chronic disease management, central services, patient safety and Emergency Measures Services.

Chronic disease management

One of Manitoba Health and Healthy Living's Strategic Priorities is to "reduce the burden of diabetes and chronic disease in the province through a holistic, integrated and coordinated approach." The plan is to address this through strong partnerships among service providers. Forty-seven communities across the province are being funded to implement chronic disease action plans, primarily addressing smoking, physical inactivity and unhealthy eating. As noted in Section 4 (Performance Measures), Manitoba's obesity rate of 18.1% remained static between 2000 and 2005, while the smoking rate declined from 25% to 20.4%.

The Committee's review indicates that RHAs are giving priority to chronic disease management. The challenge for RHAs is the creation of a strong partnership between their staff and the individual primary care physicians within their region. Many RHA interdisciplinary teams work on chronic disease management in community-health centres with little or no participation from primary care physicians, who are not well integrated into the RHA's chronic disease management initiatives.

Manitoba Health and Healthy Living has initiated Physician Integrated Networks (PIN) as one approach to primary care delivery. These PINs focus on providing additional funding to enable autonomous fee-for-service physician groups to work with nurses and other health-care professionals in interdisciplinary teams to provide more comprehensive care to patients. One PIN objective is to deliver high-quality primary care with a specific focus on chronic disease. Four PIN sites will be evaluated over the next few years and a small number of additional sites are planned. Two PIN sites in the Central RHA involve 40 of the approximately 100 primary care physicians in the RHA. According to the Central RHA this best practice has facilitated the development of a team approach to primary care delivery that includes doctors, nurses and other health-care providers.

Under the current system, apart from the PINs, there are no financial incentives in place for primary care physicians to work collaboratively with the staff of the RHAs in an interdisciplinary manner to carry out chronic disease management activities. Some primary care physicians do work closely with RHA staff on chronic disease management but they are a small percentage of all the primary care physicians in the province. Other jurisdictions, including Ontario, British Columbia and Alberta, have found that an inter-professional model of care is more likely to occur when physician compensation plans provide specific funding to enable and encourage primary care physicians to work collaboratively with other health-care disciplines to achieve good patient outcomes.

Recommendation

14.1 Manitoba Health and Healthy Living, in collaboration with the Regional Health Authorities, should accelerate the implementation of inter-disciplinary models for the effective management of chronic diseases, including financial incentives for participation by primary care physicians.

Central Services

Together with the 11 RHAs, there are three major agencies that are charged with delivering health services across Manitoba: Diagnostic Services Manitoba (DSM), Cancer Care Manitoba (CCMB) and the Addictions Foundation of Manitoba (AFM). There are also other provincial programs, such as the Renal Provincial Program, that operate throughout the province. Regional Health Authorities indicated that in those cases where they provide a level of expertise that an individual RHA does not have the capacity to deliver as effectively and efficiently on its own, they have a positive collaborative relationship with the central services.

Diagnostic Services Manitoba

Diagnostic Services Manitoba is a not-for-profit corporation created by the Manitoba Government in 2002 at the initiation of the Regional Health Authorities of Manitoba (RHAM). The RHAs had identified key issues and challenges in delivering laboratory testing and rural diagnostic imaging services. Addressing these issues involved transferring laboratory and diagnostic imaging staff and assets from the RHAs to the DSM. The process is still evolving and requires strong collaboration with all RHAs, which are in the process of negotiating purchase service agreements with the DSM. A few RHAs indicated that one of the benefits of this program was the ability to get new equipment in a cost-effective manner. This new way of delivering services will require some time before a full evaluation can be done to identify its benefits.

Cancer Care Manitoba

Cancer Care Manitoba is a corporation governed by The Cancer Care Manitoba Act, which has been in existence for a number of years and was not a product of regionalization. CCMB is charged with cancer prevention, detection, care, research and education in Manitoba. It also coordinates the cancer treatment facilities and the provision of cancer-related support and rehabilitation.

It would be difficult and costly for each RHA to provide the services that CCMB provides. The RHAs indicated that CCMB's treatment sites throughout the province allow for closer-to-home care that is of real benefit. There are currently two main sites in Winnipeg, one at Cancer Care Manitoba and one at St. Boniface General Hospital. Within the WRHA there are four chemotherapy treatment sites and in rural Manitoba there are 15, soon to be 16, chemotherapy sites.

The RHAs provide the staff for all sites in every region, while CCMB sets policies, standards and provides training/education for the health-care providers at each site. RHAs indicated they have a good working relationship with CCMB.

The Addictions Foundation of Manitoba

The Addictions Foundation of Manitoba is a provincial corporation governed by The Addictions Foundation of Manitoba Act that provides intervention, rehabilitation, prevention and educational services with regard to addictions. It serves Manitoba through 23 locations in three geographical regions, with offices in Brandon, Thompson and Winnipeg. This agency (and its predecessor, the Alcoholism Foundation of Manitoba) has been in existence for several decades. In addition to the AFM there are 10 other provincially funded addiction services. Some RHAs and Aboriginal communities have developed their own programs.

Since there is a need for this service in every RHA, strong collaboration between the RHAs, AFM and other addiction services is essential. The Review Committee, as well as many of the RHAs, believes that there needs to be better coordination of addiction services throughout the province.

All the RHAs participate in the Co-occurring Disorder Initiative, which addresses the fact that individuals with mental-health and substance-use disorders require services from both mental-health and addiction services. This initiative was launched in the Winnipeg Regional Health Authority and is co-sponsored by AFM and Manitoba Health and Healthy Living.

In August 2007, under the guidance of the Mental Health and Addictions Branch, of Manitoba Health and Healthy Living, an assessment of the adult addictions treatment system in Manitoba was begun. Based on the assessment of current gaps and the need for more integration of treatment, a strategy is being developed that can be used in the provincial and regional planning processes.

Because of the frequency that mental health and addiction issues occur together in the population, competency in both mental health and substance use is required. The Review Committee believes that addictions services and the mental health program in each region should be integrated to better treat patients that require both mental-health and addiction services and to allow each service to have easier access to patient information.

Recommendations

14.2 Manitoba Health and Healthy Living should identify how mental-health and addiction services can best be delivered in a more integrated manner at the regional level.

Patient safety

The publication of research studies regarding patient safety issues in hospitals in Canada has brought a greater awareness of its importance. As well, events such as the Manitoba Pediatric Cardiac Surgery Inquest have brought attention to the need for improvements. Patient safety is promoted across the country by organizations such as the National Steering Committee on Patient Safety and the Canadian Patient Safety Institute.

To promote patient safety, the Manitoba government amended both *The Regional Health Authorities Act* and *The Manitoba Evidence Act*. The amendments provide a more secure environment for the investigation of critical incidents, while protecting the right of affected individuals to know what has happened to them during their treatment and the consequences of any critical incidents. The Manitoba Patient Safety Institute was created to promote, coordinate and facilitate activities that have a positive impact on patient safety throughout the province.

The RHAs and health-services providers have committed to improving the safety of patients. Furthermore, patient safety has been identified by all RHAs as a priority in their strategic planning.

Some of the patient safety initiatives identified by the RHAs are:

- Participation in the Canadian Patient Safety Institute "Safer Health Care Now" initiative (this includes six interventions for quality improvement in patient safety)
- Hand Hygiene Initiative
- Regional Falls Prevention Strategy
- Critical Incident reporting
- Safe use of infusion pumps
- Establishment of designated managers to oversee patient-safety initiatives
- Extensive staff education regarding patient safety initiatives
- Involvement in the "Safe To Ask" campaign
- Implementation of the Canadian Council for Health Services Accreditation Patient Safety Goals and Organizational Practices
- Patient Safety Leadership Walk Around

Since regionalization, some RHAs have created a Risk Management position to oversee quality, risk management and patient safety. Although there is currently some monitoring of patient safety initiatives, the RHAs need to further develop this focus on patient safety and provide data that would indicate any positive outcomes of patient safety initiatives. The implementation, monitoring and measuring of the outcomes of patient safety initiatives are a major undertaking that will require the allocation of adequate funding within each RHA.

Recommendation

14.3 Regional Health Authorities should jointly develop a set of measures for evaluating the outcomes of patient safety initiatives. These measures should be used to prepare regular reports on patient safety to their Boards, to Manitoba Health and Healthy Living, and to the public.

Emergency Medical Services

Prior to regionalization, emergency medical services (EMS) (formerly known as ambulance services) were provided by licensed operators in municipalities in Manitoba. The majority of services were provided by volunteers with basic to advanced first aid and transport training.

In 1996 the responsibility for ambulance services was transferred from municipalities to the Regional Health Authorities. As well as the 11 RHAs, there are several licensed land ambulance providers. Each RHA is responsible for coordinating several EMS sites within its boundaries.

The delivery of health services continues to evolve and change in response to increased demands, increased technology, increased need for improved skills and competencies, human resource issues and the increase in cost for services. These changes have a direct impact on EMS providers. It is critical to be able to provide timely and effective care to individuals prior to hospital care. For RHAs, a key challenge has been to coordinate RHA services to ensure that EMS is available, determining where it is needed and that there is a sufficient supply of licensed paramedics.

In the last few years, Manitoba Health and Healthy Living and the RHAs have made improvements to the coordination of the EMS system. These include:

- An increased competency profile, with licensing levels for pre-hospital practitioners
- Development of a province-wide Fleetnet communication system for emergency services
- Purchase and maintenance of land ambulances
- Development of province-wide dispatch center (Medical Transportation Coordinator Centre) which is located in Brandon. It is the dedicated centre for the dispatch of all rural and northern medical services including northern medi-vacs, management and co-ordination of all inter-facility transfer across the province
- Funding of costs for patient inter-facility transfers
- A designated manager in each region to represent their regional delivery service

During the consultation process, the Review Committee received submissions from concerned citizens regarding the inequalities of the ambulance services fees in different RHAs and that the size of the fee created hardship for some residents. There

can be, for example, different billing rates for an ambulance responding to calls from outside of its regional boundary.

In discussions with the RHAs, it was found that there are RHAs that do not coordinate all the Emergency Medical Services within their region. Instead, they have purchase service agreements (PSA) with other providers. In one region, the RHA coordinates services for only one EMS site and provides partial funding to four different municipalities that coordinate the remaining services. The Review Committee would have expected that regionalization would have led to a change in the distribution of EMS across the province. However, ambulance distribution throughout the province is largely the same as it was prior to regionalization. This is most likely a result of inherited disparities from the municipal model.

The level of training required of paramedics to acquire licensure varies throughout the RHAs. The Assiniboine Regional Health Authority has implemented a best practice that allows EMS providers to maintain their licensure by completing ongoing modules at home on-line, rather than having to take examinations every three years. This makes it easier for the providers to maintain their license, a measure which positively impacts recruitment and retention. Paramedics are licensed by Manitoba Health Emergency Services after completion of the Emergency Technician training program. The paramedics practice under the regional EMS Director.

In summary, some of the disparities and problems that still exist are:

- Differences in fee structure from RHA to RHA
- Differences in education and training levels of licensed EMS providers
- Differences in staffing models for EMS from RHA to RHA
- Differences in the number and location of ambulance services in relation to geography and call volume from RHA to RHA

Recommendations

14.4 The Manitoba Government, Manitoba Health and Healthy Living, Regional Health Authorities of Manitoba, the Regional Health Authorities and stakeholders should work together to develop a province-wide ambulance service delivery system that includes a fair and equitable ambulance fee structure.

14.5 Manitoba Health and Healthy Living and the RHAs should develop performance indicators for the measurement of system outcomes for the Emergency Medical Services delivery system and improved accountability.

15. Best Practices

The Review Committee's terms of reference included the identification of areas where particular Manitoba RHAs have shown leadership and innovation (best practice) in improving patient care. In addition there was an expectation that the Review Committee would identify where best practices have been demonstrated elsewhere in Canada and the extent to which best practices from within and outside Manitoba could be applied by Manitoba RHAs.

The Review Committee asked all RHA CEOs and the CEOs of non-devolved facilities to give us examples of best practices that they have implemented. It also requested that they indicate whether an external reviewer, such as the Canadian Council for Health Services Accreditation, has validated each of these as a best practice. The Review Committee has compiled an inventory of some of the Manitoba best practices with short descriptions and included them in a separate document for use by the Manitoba RHAs. Some of these have been referenced throughout this report.

Since there is no single repository of best practices in Canada, the Review Committee also contacted a variety of national organizations to identify examples of best practices in other provinces. Some of these have also been referenced throughout this report.

Regional Health Authorities of Manitoba

The Review Committee asked CEOs of the RHAs how they learn about best practices in Manitoba and elsewhere. The most useful mechanism appears to be the Regional Health Authority of Manitoba (RHAM) Provincial Network Committees. This organization coordinates joint activities of mutual benefit for the RHAs and

assists them in improving the quality and delivery of Manitoba's health services. The following is a list of some of the RHAM Network Committees in which each RHA and staff from Manitoba Health and Healthy Living participate:

- Council of RHA Chairs
- Council of RHA Chief Executive Officers (CEOs)
- Chief Financial Officers Network Committee
- Provincial Planning Network Committee
- Health Program and Services Executive Network Committee
- Human Resources Network Committee

Most of these committees meet on a regular, often monthly, basis. According to the RHAs, the committees have proven to be a valuable means of communicating, coordinating, sharing and developing common-based protocols and policies.

In addition, the Manitoba Centre for Health Policy (MCHP) Need To Know Team enables all RHAs to understand evidence-informed reports produced by MCHP.

While there are some processes for identifying, validating and sharing best practices in Manitoba, they are somewhat informal. Having spent time interviewing staff and reading materials from all RHAs, the Review Committee believes that there are numerous best practices in RHAs which the staff of other RHAs are not aware.

Recommendation

15.1 The Regional Health Authority of Manitoba should establish formal mechanisms for inventorying, validating and sharing Manitoba Regional Health Authority best practices and best practices from other provinces to encourage and enable their implementation as appropriate throughout all Manitoba Regional Health Authorities.

16.
RECOMMENDATIONS

6.1 Manitoba Health and Healthy Living should increase the devolution of authority to Regional Health Authorities, along with a commensurate increase in accountability. The increased devolution of authority should allow Regional Health Authorities to make critical resource allocation and service planning decisions that impact quality and the availability of health services in the regions.

6.2 Manitoba Health and Healthy Living, in consultation with the Regional Health Authorities, should develop an evidence-based decision-making protocol for implementing changes in the use of regional resources. This protocol should provide guidance to the Regional Health Authorities regarding methodologies for maximizing the probability of government support for service delivery changes.

6.3 Manitoba Health and Healthy Living, in consultation with the Regional Health Authorities, should establish clear and transparent processes to provide regular and clear feedback to Regional Health Authorities on their performance measures.

7.1 The Manitoba government should make the appointment of Regional Health Authority board members and chairs more consultative, rigorous

and transparent. In consultation with the Regional Health Authorities, this process could include (a) board nominating committees; (b) required interviews for all candidates; (c) posting of minimum selection criteria; and (d) community-based nomination/selection processes that would forward a list of suitable candidates to a board nominating committee.

7.2 The following categories of individuals should be made ineligible for appointments to a Regional Health Authority board: employees who directly report to the chief executive officer of the Region, elected officials of unions representing workers at the Regional Health Authority, and elected government representatives.

7.3 Manitoba Health and Healthy Living, in consultation with the Regional Health Authorities, should develop processes to increase the accountability of boards and board members. The processes should include independent, third-party assessment of board and board member effectiveness, board accountability for empowering communities in the region, and meeting health care outcomes and service delivery objectives.

7.4 Remuneration of Regional Health Authority board members and chairs should be increased to reflect the increase in the cost of living from the time the stipends were originally established. If the authority, responsibility and accountability of Regional Health Authority boards are increased (as recommended in this review), external advice should be sought to evaluate the directors' new role and establish compensation benchmarks for directors on comparable boards.

8.1 Because of the proven success of the "grow-our-own" recruiting and retention strategies, Regional Health Authorities and Manitoba Health and Healthy Living should promote and support this as one of the primary recruiting and retention strategies.

8.2 Manitoba Health and Healthy Living should develop and implement a central long-term health-services human resource strategy for all health disciplines.

8.3 Manitoba Health and Healthy Living should implement regional accountability processes and appropriate targets for developing a workforce that reflects the Aboriginal demographics of the Regional Health Authorities.

9.1 Manitoba Health and Healthy Living should request that the Canadian Institute for Health Information audit Management Information System accounts to enable comparable benchmarking throughout Canada of the percentage of expenditures spent on administrative costs.

9.2 Manitoba Health and Healthy Living should provide incentive funding for regions to undertake leadership roles in innovative process improvement interventions that can be shared with other Regional Health Authorities.

9.3 Manitoba Health and Healthy Living should support the Regional Health Authorities to develop and implement systems to ensure effective human resource management practices and accountability processes for front-line managers and front-line staff.

10.1 Manitoba Health and Healthy Living should require Regional Health Authorities to be accountable for and report on the development of effective methods of obtaining community input through the District Health Advisory Councils, Community Health Advisory Councils or other community engagement mechanisms chosen by the region.

10.2 Regional Health Authorities should implement methods to engage and empower their communities and districts based on the following principles: (a) identifying issues of common concern to strive for a common goal, (b) identify relevant organizations and community leaders to work in a collaborative fashion, (c) provide community members with information and knowledge so that informed evidence-based decisions are made and (d) have a democratic process.

10.3 Manitoba Health and Healthy Living should establish guidelines for planning health services provincially and regionally. In doing so, it should provide a systemic, evidence-based methodology that would include input from the communities, districts and region for determining what services should be provided in each community.

10.4 All Regional Health Authorities, in collaboration with their communities and using benchmarks from other jurisdictions, should develop and publish regional service plans that specify the appropriate mix, capacity and location of services in their region.

10.5 Manitoba Health and Healthy Living should establish a provincial comparative performance indicator database to enable performance

indicator target setting within the Regional Health Authorities and negotiated quantitative target setting between Manitoba Health and Healthy Living and the Regional Health Authorities for improving health status, service delivery and outcomes through accountability on these measures and targets.

11.1 Manitoba Health and Healthy Living, in collaboration with the Regional Health Authorities, should implement a transparent methodology for funding Regional Health Authorities that allocates funds based on differences in regional population needs as well as providing explicit financial incentives to increase service volumes and performance where appropriate.

11.2 Manitoba Health and Healthy Living, in collaboration with the Regional Health Authorities, should establish funding methodologies for Regional Health Authorities to fund personal care homes and hospitals based on the volume and level of care requirements of the residents/patients that they serve.

11.3 The Government of Manitoba should modify funding processes to enable specific operating budget allocations to Regional Health Authorities and from Regional Health Authorities to their cost-centre managers and non-devolved organizations well in advance of the beginning of their budget year as well as providing targets for the second and third years.

11.4 All Regional Health Authorities and their non-devolved organizations should utilize national peer group best quartile benchmarks for clinical and operational efficiency to improve the sophistication of their budgeting processes to enable efficient operations and internal reallocation of resources.

11.5 The Government of Manitoba should pursue a variety of alternative financing options, such as public/private partnerships for the construction of facilities, the leasing of equipment and the use of external service providers for information and communication technology services and diagnostics, that would enable the greater use of capital by the Regional Health Authorities for safe, efficient and effective care.

12.1 The Government of Manitoba should make a public commitment to health-service related information and communication technologies, commit itself to the appropriate level of funding and ensure that its

information and communication technologies initiative has effective project management.

12.2 Manitoba Health and Healthy Living should contract with an external consulting group to conduct an annual risk review on the progress being made in the implementation of the Manitoba eHealth strategy.

12.3 Manitoba Health and Healthy Living should take steps to accelerate the implementation of clinical telemedicine throughout Manitoba to enable efficient and effective care close to home to make regionalization function more effectively.

12.4 Manitoba Health and Healthy Living and the Winnipeg Regional Health Authority should ultimately include all Regional Health Authorities in establishing shared business information and communications technologies solutions to provide transaction based services for human resources, financial accounting and supply management.

13.1 Manitoba Government, Manitoba Health and Healthy Living, Regional Health Authorities, First Nation representatives and the federal government should resolve jurisdictional and funding issues in an expeditious manner.

13.2 The Regional Health Authorities, with assistance from Manitoba Health and Healthy Living, should address the health and health services needs of Aboriginal people by setting specific targets for improvement in health and health services outcomes.

14.1 Manitoba Health and Healthy Living, in collaboration with the Regional Health Authorities, should accelerate the implementation of inter-disciplinary models for the effective management of chronic diseases, including financial incentives for participation by primary care physicians.

14.2 Manitoba Health and Healthy Living should identify how mental-health and addiction services can best be delivered in a more integrated manner at the regional level.

14.3 Regional Health Authorities should jointly develop a set of measures for evaluating the outcomes of patient safety initiatives. These measures should be used to prepare regular reports on patient safety to their Boards, to Manitoba Health and Healthy Living, and to the public.

14.4 The Manitoba Government, Manitoba Health and Healthy Living, Regional Health Authorities of Manitoba, the Regional Health Authorities and stakeholders should work together to develop a province-wide ambulance service delivery system that includes a fair and equitable ambulance fee structure.

14.5 Manitoba Health and Healthy Living and the RHAs should develop performance indicators for the measurement of system outcomes for the Emergency Medical Services delivery system and improved accountability.

15.1 The Regional Health Authority of Manitoba should establish formal mechanisms for inventorying, validating and sharing Manitoba Regional Health Authority best practices and best practices from other provinces to encourage and enable their implementation as appropriate throughout all Manitoba Regional Health Authorities.

Appendix 1: Biographies of External Review Committee Members

Jerry Gray, chair of the review, is dean emeritus and senior scholar at the I. H. Asper School of Business. He is a recognized authority on organizational design, managerial leadership and organizational development. He also served as the co-chair of the Premier's Economic Advisory Council health-care summit in 2006.

Shirley Delaquis worked as a Registered Nurse and retired after a lengthy nursing career at the St. Boniface General Hospital. She was full-time president of St. Boniface Nurses Union Local 5 for five years; was a member of the Manitoba Nurses Union Board of Directors for eight years and was a founding member of the National Federation of Nurses Unions (now, the Canadian Federation of Nurses Unions). She also served as a member of the first board of directors with the Winnipeg Regional Health Authority for five years (2000-2005). From 2004 to 2006, she was a member of the Winnipeg Regional Health Authority Emergency Care Task Force, which provided recommendations to improve emergency care in Winnipeg hospitals. Currently, she serves as the chair of the Manitoba Civil Service Commission.

Tom Closson's career has been devoted to the improvement of health-care systems through his work in government, health-services management and as a consultant. In recent years, he has been the president and chief executive officer of major hospitals in Ontario and a health region in British Columbia, and has served as special advisor to Ontario's health minister.

Appendix 2: Newspaper advertisements

COMITÉ DE L'EXAMEN EXTERNE

Faites connaître votre point de vue

sur le système des offices régionaux de la santé du Manitoba

Le gouvernement du Manitoba a créé un comité indépendant d'examen externe pour évaluer le système provincial des offices régionaux de la santé (ORS). Ce comité d'examen a comme objectif d'émettre des recommandations sur la façon d'améliorer les services de soins de santé pour les Manitobains et Manitobaines.

Le comité de l'examen externe est composé des membres suivants :

- M. Jerry Gray, doyen émérite et chercheur principal de l'I.H. Asper School of Business de l'Université du Manitoba;
- M^me^ Shirley Delaquis, infirmière ayant récemment pris sa retraite;
- M. Tom Closson, ancien président-directeur général de grands hôpitaux en Ontario et d'une région sanitaire en Colombie-Britannique.

Les membres du comité de l'examen externe ont comme tâches les suivantes :

- évaluer l'efficacité en général du système des ORS;
- déterminer les domaines dans lesquels des ORS ont fait preuve d'innovation quant à l'amélioration des soins aux patients;
- émettre des recommandations sur la façon dont les pratiques exemplaires peuvent être appliquées dans tous les ORS;
- vérifier que les ressources sont concentrées principalement sur les soins aux patients de première ligne en analysant les coûts administratifs et en comparant ceux-ci aux coûts dans d'autres provinces et territoires;
- examiner les façons dont les ORS peuvent accroître leur obligation redditionnelle à l'égard du public;
- trouver des moyens de favoriser la participation de la collectivité dans la prise de décisions à l'échelle régionale.

Soumettez vos observations écrites

Le comité d'examen veut savoir ce que vous avez à dire au sujet des offices régionaux de la santé du Manitoba et vous invite à soumettre des observations écrites sur les questions traitées dans le cadre de son mandat. Vous pouvez envoyer vos observations écrites par la poste ou par courrier électronique.

Adresse postale – Comité d'examen des ORS, C.P. 48065, comptoir postal Lakewood, Winnipeg (Manitoba) R2J 4A3

Adresse de courriel – rhareview@shaw.ca

Veuillez soumettre vos observations écrites d'ici le **22 août 2007**.

Renseignements supplémentaires

Pour obtenir plus de renseignements sur le mandat détaillé du comité d'examen, visitez la page Web à l'adresse **www.gov.mb.ca/health/rha/review.fr.html**.

Tous les renseignements personnels, y compris les renseignements médicaux, que vous fournissez au comité d'examen dans le cadre de la consultation sont protégés par la *Loi sur l'accès à l'information et la protection de la vie privée* et la *Loi sur les renseignements médicaux personnels*. Les renseignements que vous fournissez ne serviront qu'à aider le comité d'examen à s'acquitter de ses responsabilités. Ceci nécessitera la divulgation des renseignements aux membres du comité d'examen qui les échangeront entre eux, aux personnes fournissant un soutien administratif, à d'autres participants de l'examen et aux autres parties intéressées. Cette divulgation sera faite de diverses manières, au cours du processus d'examen et après celui-ci, notamment au moyen de rapports écrits. **Votre identité ne sera pas divulguée sans votre consentement**. Si vous avez des questions sur la collecte, l'utilisation ou la divulgation de vos renseignements personnels, y compris vos renseignements médicaux, veuillez communiquer avec la coordonnatrice du comité d'examen par téléphone, en composant le 204 786-7347, ou par écrit, à l'adresse suivante : C.P. 48065, comptoir postal Lakewood, Winnipeg (Manitoba) R2J 4A3.

Manitoba

EXTERNAL REVIEW COMMITTEE

Share Your Views

on Manitoba's Regional Health Authority System

The Manitoba government has established an independent external committee to review the province's regional health authority system. The goal of this review committee is to make recommendations to improve health care services for all Manitobans.

The external review committee consists of the following members:

- Dr. Jerry Gray, dean emeritus and senior scholar at the University of Manitoba's I.H. Asper School of Business
- Ms Shirley Delaquis, a recently retired nurse
- Mr. Tom Closson, the former president and chief executive officer of major hospitals in Ontario and a British Columbia health region

They are expected to achieve the following objectives:

- Examine the overall performance of the RHA system
- Identify areas where regional health authorities (RHAs) have shown innovation in improving patient care
- Recommend how best practices can be extended to all RHAs
- Ensure resources are focused on front-line patient care by reviewing administrative costs, including comparisons to other jurisdictions
- Examine how RHAs can increase their public accountability
- Identify ways to enhance community participation in regional decision making

Send your written submission

The review committee wants to hear what you have to say regarding Manitoba's RHAs and invites you to send a written submission related to topics within its mandate. You can send your submission by either post or e-mail.

Mailing address – RHA Review Committee, P.O. Box 48065 RPO Lakewood, Winnipeg, MB R2J 4A3

E-mail: rhareview@shaw.ca

Please send your written submission by **August 22, 2007.**

For more information

If you would like more information on the review committee's detailed terms of reference, please visit **www.gov.mb.ca/health/rha/review.html**

Any personal information, and personal health information, you provide to the review committee as part of the consultation is subject to *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The information you provide will only be used to assist the review committee in carrying out its responsibilities. This will involve disclosure of the information to and between members of the review committee, persons providing administrative support, to other review participants, other interested parties and through various means, during and after the review process, including written reports. **Your personal identity will not be disclosed without your consent.** If you have any questions about the collection, use or disclosure of your personal information or personal health information, please contact the review committee coordinator at P.O. Box 48065 RPO Lakewood, Winnipeg MB R2J 4A3 or (204) 786-7347.

Manitoba

Appendix 3: Questionnaire for Regional Health Authority Board Chairs and CEOs

Accountability Relationship with the Department

1) To what extent does the devolution of decision making authority from the Ministry enable the RHA to function effectively and responsively? Give examples.

2) To what extent are the Department accountability tools and processes efficient and effective?

Governance of the RHA

3) How does your RHA Board measure and ensure that it has an appropriate skill mix?

4) How does your Board measure and ensure its members are educated on the affairs of the RHA?

5) What performance information does your Board regularly receive?

6) How is your Board involved in establishing priorities, strategies and policies?

7) How does your Board ensure management's accountability?

8) How does your Board identify, prevent and manage risks to the organization?

Planning

9) How does your RHA work with the community and non-devolved organizations to assess regional health status and needs?

10) How are the community and non-devolved organizations involved in planning and decision-making?

11) How have provincial program priorities affected the RHAs ability to deliver its regional priorities?

12) How effectively does the model of Central Program Agencies function for each of Cancer, Addictions and Diagnostics?

13) What service relationships has your RHA established with aboriginal peoples in your region and how effective are they?

14) What progress has been made to address regional priorities in the past 10 years? Give examples.

Funding and Finance

15) How equitable is Government funding for the people served by your RHA compared to other RHAs?

16) How does the timing of Government funding announcements impact on your ability to achieve regional and provincial priorities?

17) What is your process for developing the operating budget of your RHA? How do you address the needs of the non-devolved facilities?

18) Are resources reallocated across cost centres and sectors to address priorities? Give examples.

19) What is your process for developing building, equipment and ICT budgets? How do you address the needs of the non-devolved facilities?

20) Describe your use of benchmarking in the development of operating and capital budgets?

21) What has been the magnitude ($s and %) of any operating deficit or surplus of the RHA in each of the past 3 years according to its audited statements?

Human Resources

22) How successful are you in attracting and retaining a full complement of employees and physicians? What mechanisms have you used?

23) How successful has your RHA been in establishing a workforce that reflects the region's workforce? What strategies has the RHA used?

24) How is medical staff organized throughout the region to ensure quality and availability?

Geographic Boundaries

25) How effective are the systems and processes for integrating services to patients across RHA boundaries?

26) What are the implications of the consistency of RHA, family services, municipal and education system boundaries for addressing the determinants of health for your RHA?

27) What changes would you propose, if any, to the existing RHA boundaries? Why?

Service Delivery

28) What initiatives have been undertaken to achieve interdisciplinary care?

29) What systems and processes do you have in place to manage the integration of care between sectors (e.g., hospitals, home care, etc.)?

30) What systems and processes are in place for chronic disease management? Give examples.

31) What initiatives have you established to encourage healthy living?

32) What incentives are used to ensure that provider organizations/practitioners work in alignment with each other?

33) What major initiatives have been undertaken in recent years to increase service cost effectiveness?

34) What systems and procedures do you have in place to monitor ongoing service delivery performance and to take corrective action?

Information and Communications Technologies

35) To what extent have electronic health records systems been implemented within the region enabling practitioners to share access to patient information? Give examples.

36) How is clinical telemedicine used in the region to enable more equitable access to care? Give examples.

37) To what extent are shared business IT solutions (e.g., a common payroll system) used in the region?

Quality Management

38) What processes are used by your RHA for continuous quality improvement across the continuum of care?

39) To what extent is data readily available to track patients across sectors for quality improvement?

40) To what extent are common evidence based protocols used throughout the region and between regions to ensure quality care? Give examples.

41) How does your RHA balance the concepts of "closer to home" and "practice makes perfect" (i.e., achieving better outcomes with greater volumes)

42) What initiatives are underway in your Region to address patient safety?

Management and Organization

43) What steps has your RHA taken to find efficiencies in administrative costs?

44) What steps has your RHA taken to implement the optimal number of layers of management?

45) What innovative management strategies and systems (e.g., lean principles) has your RHA experimented with or implemented?

46) Describe the extent to which your managers are empowered to make decisions.

Outcomes

47) What performance measures does the RHA routinely use for measuring outcomes?

Best Practices

48) Give some examples of best practices that have been implemented in your RHA. Indicate whether each one has been validated as a "best practice" by some external reviewer (e.g., CCHSA).

Any personal information and personal health information, you provide to the Review Committee as part of the consultation is subject to *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The information you provide will only be used to assist the Review Committee in carrying out its responsibilities. This will involve disclosure of the information to and between members of the Review Committee, persons providing administrative support, to other review participants, other interested parties and through various means, during and after the review process, including written reports. Your personal identity will not be disclosed without your consent. If you have any questions about the collection, use or disclosure of your personal information or personal health information, please contact the Review Committee Coordinator at P.O. Box 48065 RPO Lakewood, Winnipeg MB R2J 4A3 or (204) 786-7347.

Appendix 4: Questionnaire for Non-Devolved Facilities

Accountability Relationship with RHA

1) To what extent does your planning process and decision making authority in relation to the RHA enable/inhibit your facility to function effectively and responsively?

Governance

2) How does your facility Board establish priorities, strategies and policies that integrate with RHA priorities, strategies and policies to provide a continuum of care?

Planning

3) How effectively does the model of Central Program Agencies function for each of Cancer, Addictions and Diagnostics?

Funding and Finance

4) How does the timing of Government/RHA funding announcements impact your ability to achieve priorities?

5) What is your process for developing your operating budget? How well does this process link with the process used by the RHA?

6) What is your process for developing building, equipment and ICT budgets? How well does this process link with the process used by the RHA?

7) What has been the magnitude ($s and %) of any operating deficit or surplus of your facility in each of the past 3 years according to its audited statements?

8) What steps has your facility taken to find efficiencies in administrative costs?

Human Resources

9) How successful are you in attracting and retaining a full complement of employees and physicians? What mechanisms have you used?

10) What initiatives have been undertaken to achieve interdisciplinary care?

Service Delivery

11) How effective are your systems and processes to manage the integration of care between sectors (e.g., hospitals, home care, PCHs, etc.) to enable you to provide the necessary care to your patients/residents?

12) What major initiatives have been undertaken in recent years to increase service cost effectiveness?

Information and Communications Technologies

13) To what extent have electronic health records systems been implemented within the region enabling practitioners from your facility to share access to patient information? Give examples.

14) How is clinical telemedicine used in the region to enable more equitable access to care by your patients/residents? Give examples.

15) To what extent are shared business IT solutions used in the region?

Quality Management

16) What processes are used by your facility for continuous quality improvement across the continuum of care?

17) To what extent is data readily available to track patients across sectors for quality improvement?

18) To what extent are common evidence based protocols used throughout the region and between regions to ensure quality care? Give examples.

19) What initiatives are underway in your facility to address patient safety?

Outcomes

20) What performance measures does your facility routinely use for measuring outcomes?

Best Practices

21) What innovative management strategies and systems (e.g., lean principles) has your facility experimented with or implemented?

22) Give some examples of best practices that have been implemented in your facility. Indicate whether each one has been validated as a "best practice" by some external reviewer (e.g., CCHSA).

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Appendix 5: Non-Devolved Facilities Receiving Questionnaire

Brandon Health Region
Central Park Lodge — Valleyview
Dinsdale Personal Care Home
Hillcrest Place Inc.

Burntwood Health Region
Nisichawayasihk Personal Care Home
Pinaow Wachi Inc.

Central Health Region
Prairie View Lodge
Rock Lake Personal Care Home
Salem Home Inc.
Tabor Home Inc.

Interlake Health Region
Betel Home Foundation
Red River Place
Tudor House Personal Care Home

Parkland Health Region
Dr. Gendreau Personal Care Home
McCreary/Alonsa Health Centre Personal Care Home
St. Paul's Home
Winnipegosis and District Health Centre

South Eastman Region
Menno Home for the Aged
Rest Haven Nursing Home
St. Adolphe Personal Care Home
Villa Youville Incorporated

Winnipeg Health Region
Beacon Hill Lodge
Bethania Mennonite Personal Care Home, Inc.
Calvary Place Personal Care Home
Central Park Lodge — Parkview Place

Central Park Lodge — Poseidon Care Centre
Centre Taché Centre
Charleswood Care Centre
Concordia Place
The Convalescent Home of Winnipeg
Donwood Manor Personal Care Home Inc.
Fort Garry Care Centre Ltd.
Foyer Valade
Fred Douglas Lodge
Golden Door Geriatric Centre
Golden Links Lodge
Golden West Centennial Lodge
Heritage Lodge Personal Care Home
Holy Family Nursing Home
Kildonan Personal Care Centre Inc.
Lions Personal Care Centre
Luther Home
Maples Personal Care Home
Meadowood Manor
The Middlechurch Home of Winnipeg
Misericordia Place
Oakview Place
Park Manor Personal Care Home, Inc.
Pembina Mennonite Personal Care Home
River East Personal Care Home Ltd.
Riverview Health Centre
The Saul and Claribel Simkin Centre of The Sharon Home Inc.
The Sharon Home Inc.
St. Joseph's Residence Inc.
St. Norbert Nursing Home
Tuxedo Villa
Vista Park Lodge
West Park Manor Personal Care Home

Appendix 6: Questionnaire for First Nations Organizations

Please indicate the name of your Regional Health Authority (RHA):

A. Planning

1) Are First Nations values incorporated in the planning process of your RHA? If so, how?

2) Is First Nations culture incorporated in the planning process of your RHA? If so, how?

3) Are First Nations health needs incorporated in the planning process of your RHA? If so, how?

4) Can you suggest any changes that might enhance the RHA planning process?

B. Governance

5) Are First Nation people represented on your RHA board? If so, how effective is this representation in influencing Métis health care issues?

6) Are First Nation people represented on the District Health Councils/ Community Advisory Councils in your RHA? If so, how effective is this representation in influencing Métis health care issues?

7) Can you suggest any changes that could be made to improve the effectiveness of First Nation people in the governance of your RHA?

C. Human Resources

8) How successful has your RHA been in establishing a workforce that is representative of First Nations people in your region?

9) Can you suggest any strategies that RHAs might use to enhance First Nation representation?

D. Service Delivery

10) Has your RHA established service relationships with First Nation people in your area? If so, how effective has this been?

11) Has your RHA collaborated with First Nations in developing a process to help manage chronic diseases such as diabetes or heart disease? If so, how effective has this been?

12) Can you suggest any changes that might enhance this area?

13) Has your RHA collaborated with First Nations in developing a process to help manage the integration of care between sectors (e.g. hospitals, home care, etc.)? If so, how effective has this been?

14) Can you suggest any changes that might enhance this area?

15) Has your RHA collaborated with First Nations in developing a process to encourage healthy living? If so, how effective has this been?

16) Can you suggest changes that might enhance this area?

17) Has your RHA collaborated with First Nations in developing a system to monitor service delivery performance specific to First Nation's people? If so, how effective has this been?

18) Does this system allow for corrective action?

19) Can you suggest changes that might improve this area?

E. Best Practices

20) Can you provide any 'Best Practices' that have been implemented to improve health and health care delivery for First Nations people?

21) Was the RHA involved in this? If so, how?

F. Other

22) Please comment on any other issue you feel would help the committee in the external review of the Regional Health Authority system.

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Committee in carrying out its responsibilities. This will involve disclosure of the information to and between members of the Review Committee, persons providing administrative support, to other review participants, other interested parties and through various means, during and after the review process, including written reports. Your personal identity will not be disclosed without your consent. If you have any questions about the collection, use or disclosure of your personal information or personal health information, please contact the Review Committee Coordinator at P.O. Box 48065 RPO Lakewood, Winnipeg MB R2J 4A3 or (204) 786-7347.

Appendix 7: Questionnaire for Metis Organizations

Please indicate the name of your Regional Health Authority (RHA):

A. Planning

1) Are Métis values incorporated in the planning process of your RHA? If so, how?

2) Is Métis culture incorporated in the planning process of your RHA? If so, how?

3) Are Métis health needs incorporated in the planning process of your RHA? If so, how?

4) Can you suggest any changes that might enhance the RHA planning process?

B. Governance

5) Are Métis people represented on your RHA board? If so, how effective is this representation in influencing Métis health care issues?

6) Are Métis people represented on the District Health Councils/Community Advisory Councils in your RHA? If so, how effective is this representation in influencing Métis health care issues?

7) Can you suggest any changes that could be made to improve the effectiveness of Métis people in the governance of your RHA?

C. Human Resources

8) How successful has your RHA been in establishing a workforce that is representative of Métis people in your region?

9) Can you suggest any strategies that RHAs might use to enhance Métis representation?

D. Service Delivery

10) Has your RHA established service relationships with Métis people in your area? If so, how effective has this been?

11) Has your RHA collaborated with Métis in developing a process to help manage the integration of care between sectors (e.g. hospitals, home care, etc.)? If so, how effective has this been?

12) Can you suggest any changes that might enhance this area?

13) Has your RHA collaborated with Métis in developing a process to encourage healthy living? If so, how effective has this been?

14) Can you suggest changes that might enhance this area?

15) Has your RHA collaborated with Métis in developing a system to monitor service delivery performance specific to Métis people? If so, how effective has this been?

16) Does this system allow for corrective action?

17) Can you suggest changes that might improve this area?

E. Best Practices

18) Can you provide any 'Best Practices' that have been implemented to improve health and health care delivery for Métis people?

19) Was the RHA involved in this? If so, how?

F. Other

20) Please comment on any other issue you feel would help the committee in the external review of the Regional Health Authority system.

Any personal information, and personal health information, you provide to the Review Committee as part of the consultation is subject to *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The information you provide will only be used to assist the Review Committee in carrying out its responsibilities. This will involve disclosure of the information to and between members of the Review Committee, persons providing administrative support, to other review participants, other interested parties and through various means, during and after the review process, including written reports. Your personal identity will not be disclosed without your consent. If you have any questions about the collection, use or disclosure of your personal information or personal health information, please contact the

Review Committee Coordinator at P.O. Box 48065 RPO Lakewood, Winnipeg MB R2J 4A3 or (204) 786-7347.

Appendix 8: Questionnaire for Community Health Advisory Councils/District Health Advisory Councils Chairs

1. Explain how your current Council model provides a mechanism for community consultation into the planning and delivery of quality health services in your community?

2. Provide examples of how the linkage between your Council and the region increases awareness of unique health needs and issues for the population served?

3. What is the process for evaluating the effectiveness of your Council? What, if any, changes have you made as a result of your evaluation?

4. Explain the process for selecting people to become members of your Council?

5. What steps have you taken to improve community participation?

6. What suggestions would you have for improving community participation?

7. What is the term of office for members on your Council?

8. Other comments?

Appendix 9: The Survey for RHA Managers

WELCOME! Please answer the questions below with regard to your RHA. Please use the boxes following each question to provide more information.

1 Please identify the Regional Health Authority in which you manage. (Select from the drop down list).

2 Please indicate which of the following applies to you. WHEN YOU ANSWER THE QUESTIONS THAT FOLLOW THIS ONE, PLEASE DO SO IN REFERENCE TO YOUR RHA.

- ☐ RHA MANAGER
- ☐ FACILITY MANAGER

3 The organization is able to respond quickly to changes in its environment.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

4 Comments on your above answer.

5 The corporate culture encourages and supports change.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

6 Comments on your above answer.

7 The corporate culture encourages people to strive for high performance.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

8 Comments on your above answer.

9 The corporate culture supports innovation and risk-taking.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

10 Comments on your above answer.

11 The organization is effective at managing change.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

12 Comments on your above answer.

13 There is sufficient opportunity to participate in decisions that affect me.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

14 Comments on your above answer.

15 I feel empowered to make decisions within the scope of my job.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

16 Comments on your above answer.

17 My job allows me to develop and implement innovative changes.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

18 Comments on your above answer.

19 I feel my managerial skills are being adequately utilized.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

20 Comments on your above answer.

21 I feel the number of levels of management in this organization is appropriate.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

22 Comments on your above answer.

23 The overall "feel" of this organization is positive.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

24 Comments on your above answer.

25 Most of my colleagues speak highly of this organization.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

26 Comments on your above answer.

27 There is clear individual accountability in the organization.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

1 2 3 4 5

28 Comments on your above answer.

Any personal information, and personal health information, you provide to the Review Committee as part of the consultation is subject to The Freedom of Information and Protection of Privacy Act and The Personal Health Information Act. The information you provide will only be used to assist the Review Committee in carrying out its responsibilities. This will involve disclosure of the information to and between members of the Review Committee, persons providing administrative support, to other review participants, other interested parties and through various means, during and after the review process, including written reports. Your personal identity will not be disclosed without your consent. If you have any questions about the collection, use or disclosure of your personal information or personal health information, please contact at the Review Committee Coordinator at P.O. Box 48065 RPO Lakewood, Winnipeg MB R2J 4A3 or (204) 786-7347.

Thank you
Please hit the submit button to record your responses.

SUBMIT

Appendix 10: The RHA Governance Survey

WELCOME!
First we are asking a few questions about your board and how long you have been on it.

1 Please identify the Regional Health Authority in which you are a board member. (Select from the drop down list).

2 How long have you been a member of this board (in years)?

Using a scale from 1 to 6 where 1 is strongly agree, 2 is agree, 3 is neither agree nor disagree, 4 is disagree, 5 is strongly disagree and 6 is don't know, please answer the following questions:

3 The Board selection process is focused on achieving the proper mix of skills of Board members.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

4 Comments on your above answer

5 Board members currently have the mix of skills necessary for an effective Board.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disgree	Don't Know
1	2	3	4	5	6

6 Comments on your above answer

7 New Board members receive an appropriate orientation.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

8 Comments on your above answer

9 Board appointments are appropriately staggered to achieve continuity of knowledge.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

10 Comments on your above answer.

11 Board members have a good understanding of the community health assessment.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

12 Comments on your above answer.

13

The Board ensures that its strategic directions and goals are effectively translated into an annual operating plan by the CEO.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

14 Comments on your above answer.

15 The Board regularly considers the input from community/district advisory councils.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

16 Comments on your above answer.

17 The Board is generally and sufficiently well informed and aware of stakeholder issues, complaints and concerns.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

18 Comments on your above answer.

19 Board members come to Board meetings having read the materials in advance of the meeting.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know

1	2	3	4	5	6

20 Comments on your above answer.

21 When proposals or requests for decisions are forthcoming from senior management, the Board receives sufficient information to understand the risks, benefits, assumptions and alternatives.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

22 Comments on your above answer.

23 There is sufficient opportunity for all Board members to be heard and have their views considered before decisions are taken.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

24 Comments on your above answer.

25 Senior management accepts and acts on Board directions as the Board intends such actions to be carried out.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

26 Comments on your above answer.

27 Information provided to the Board by senior management enables the Board to adequately monitor organizational performance and measure progress or results.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

28 Comments on your above answer.

29 All Board members participate in the CEO's performance appraisal.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

30 Comments on your above answer.

Continue to the next page, hit "submit".

SUBMIT

Survey Pag

The RHA Governance Survey

31 The Board committee(s) that I participate on are effective.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

32 Comments on your above answer.

33 The Board avoids excessive involvement in detail, operational issues or in day-to-day management.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't know
1	2	3	4	5	6

34 Comments on your above answer.

35 In general, I am satisfied with how this Board functions.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

36 Comments on your above answer.

37 I feel that the Board adds value and leadership to the work of the CEO.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

38

Comments on your above answer.

39 Please add any additional information you feel the External Review Committee would find helpful.

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Thank you
Please hit the submit button to record your responses.

SUBMIT

Appendix 11: The Community Advisory Council, District Advisory Council and Stakeholders' Group Representatives Survey

WELCOME! In this questionnaire we are going to collect some information about your council.
PLEASE NOTE: THE TERM "COUNCIL" REFERS TO COMMUNITY ADVISORY COUNCILS, DISTRICT ADVISORY COUNCILS AND STAKEHOLDER GROUP REPRESENTATIVES.

1 Please identify the Regional Health Authority in which your council operates. (Select from the drop down list).

2 How long have you been on the council (in years)?

Please answer the following questions about your council. Responses range from Strongly Agree to Strongly Disagree and "Don't Know"
You may use the box below each question to provide more information about your answer.

3 My Council is an effective means of providing input into the RHA.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

4 Comments on your above answer.

5 The method of appointing individuals to my Council is effective.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

6 Comments on your above answer.

7 I can see the impact of my Council's recommendations in my region.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

8 Comments on your above answer.

9 Community Participation in my RHA decisions is effective.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

10 Comments on your above answer.

11 My Council is sufficiently informed by the RHA regarding regional issues.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

12 Comments on your above answer.

13 My Council has resulted in improved health care in my region

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

14 Comments on your above answer.

15 I feel I am an effective member of my Council.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

16 Comments on your above answer.

17 My Council provides for a free expression of ideas.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

18 Comments on your above answer.

19 The number of Council meetings per year is appropriate.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

20 Comments on your above answer.

21 My Council meetings are productive.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

22 Comments on your above answer.

23 My Council regularly evaluates its effectiveness

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

24 Comments on your above answer.

25 The orientation for new members is effective.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
1	2	3	4	5	6

26 Comments on your above answer.

27 Please add any additional information you feel the External Review Committee would find helpful.

Any personal information, and personal health information, you provide to the Review Committee as part of the consultation is subject to The Freedom of Information and Protection of Privacy Act and The Personal Health Information Act. The information you provide will only be used to assist the Review Committee in carrying out its responsibilities. This will involve disclosure of the information to and between members of the Review Committee, persons providing administrative support, to other review participants, other interested parties and through various means, during and after the review process, including written reports. Your personal identity will not be disclosed without your consent. If you have any questions about the collection, use or disclosure of your personal information or personal health information, please contact at the Review Committee Coordinator at P.O. Box 48065 RPO Lakewood, Winnipeg MB R2J 4A3 or (204) 786-7347.

Thank you
Please hit the submit button to record your responses.

SUBMIT

Appendix 12: List of Organizations Receiving Request for Input

A letter with a requests for input and a copy of the Terms of Reference were sent to:

Regional Health Authorities

- Brandon Regional Health Authority Provider Health Advisory Committee
- District/Community Health Advisory Councils*
- Manitoba's 58 non-devolved personal care homes and 14 non-devolved hospitals*
- Medical Advisory Committees from each RHA
- RHA CEOs and Board Chairs*
- RHA Regional Stakeholder Representatives (in Central RHA)

Regulated health professions

- College of Licensed Practical Nurses of Manitoba
- College of Midwives of Manitoba
- College of Occupational Therapy
- College of Physicians and Surgeons of Manitoba
- College of Physiotherapy
- College of Registered Nurses of Manitoba
- College of Registered Psychiatric Nurses of Manitoba

Health-care unions and bargaining agents

- Canadian Union of Public Employees (CUPE)
- International Union of Operating Engineers (IUOE)
- Manitoba Association of Healthcare Professionals (MAHCP)
- Manitoba Council of Health Care Unions (MCHCU)
- Manitoba Government Employees' Union (MGEU)
- Manitoba Medical Association
- Manitoba Nurses' Union (MNU)
- Paramedic Association of Manitoba
- Public Service Alliance Canada (PSAC)
- Service Employees International Union (SEIU)
- United Food and Commercial Workers Local 1869 (UFCW Local 1869)
- United Food and Commercial Workers Local 832 (UFCW Local 832)

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* Also received a questionnaire or survey.

Education facilities related to health care

- Collège Universitaire de St. Boniface
- Dean of Applied Sciences, Red River College
- Director and Assistant Professor School of Health and Human Services, Assiniboine Community College
- Faculty of Dentistry, University of Manitoba
- Faculty of Medicine, University of Manitoba
- Faculty of Nursing, University of Manitoba
- Faculty of Pharmacy, University of Manitoba
- Faculty of Rehabilitation, University of Manitoba
- School of Health Studies, Brandon University
- University College of the North (Midwife training)

Provincial Health Network Chairpersons

- Health Programs and Services Executive Network
- Chief Financial Officers
- Chief Information Officers
- Provincial Planning Network

Manitoba Health and Healthy Living

- Senior Managers

Central Medical Service Agencies

- Addictions Foundation of Manitoba
- Cancer Care Manitoba,
- Diagnostic Services of Manitoba

Other Organizations/Corporations

- Association of Manitoba Municipalities
- Catholic Corporation of Manitoba
- Catholic Health Association of Manitoba
- Conseil Communité en Santé Resource
- Government of Nunavut
- Interfaith Health Care Association of Manitoba
- Long Term Care Association of Manitoba
- Patient Safety Institute
- Societé Franco-Manitobaine

Business organizations

- Business Council of Manitoba
- Manitoba Chamber of Commerce
- Winnipeg Chamber of Commerce

Aboriginal organizations

- Assembly of Manitoba Chiefs*
- Manitoba Keewatinook Ininew Okimowin
- Manitoba Metis Federation**
- Southern Chiefs' Organization

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* Questionnaire also sent to Health Directors.

** Also received a questionnaire or survey.

Appendix 13: Advisory Committee to the RHA External Review Committee – Terms of Reference

Members:

- Randy Lock, Executive Director, Regional Health Authorities of Manitoba (RHAM)
- Larry Hogue, Chair, Council of Chairs of Regional Health Authorities (RHAs) – also Chair of Brandon RHA
- Brian Postl on behalf of RHA Chief Executive Officers (CEOs) – also CEO of Winnipeg RHA
- Donna Forbes, Assistant Deputy Minister of Regional Affairs, Manitoba Health
- Heather Reichert, Chief Financial Officer, Manitoba Health
- Review Coordinator: Joanna Plater, Manitoba Health

Roles and Responsibilities:

- To assist the Review Committee in obtaining information.
- To serve as a sounding board for the Committee re: issues, process, etc.
- To review the committee's analysis and recommendations

Communication:

- To meet on a regular basis, as required by the Review Committee and based on discussions with the Advisory Committee.
- Establish ongoing communication as necessary.
- All communication will be considered confidential.